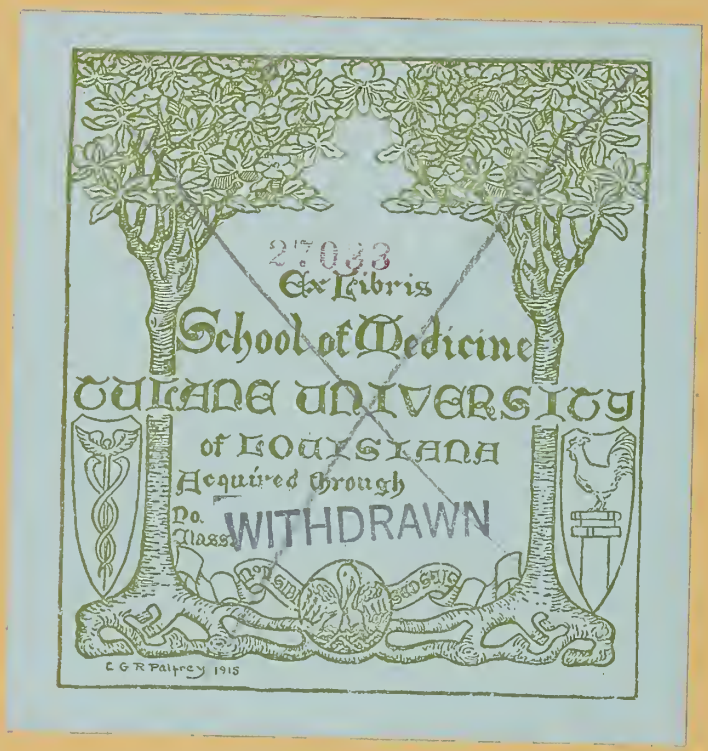
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ORIGINAL ARTICLES

PENETRATING WOUNDS OF THE SKULL*

(RECOVERY IN AN UNUSUAL CASE)

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HAMMOND

Perforation of the skull by large objects, with massive destruction of bone and brain substance, is at times followed by recovery. This fact is well recognized, and a review of the literature will reveal that the subject has been widely written upon. It is equally true that small, penetrating wounds of the skull are often as serious, or more so, than those with large openings and extensive destruction of tissue.

During the Great War there were many cases of wounds with loss of large amounts of cerebral substance, with recovery, and many of them illustrate the ability of the brain apparently to create or educate substitute centers. By appropriate educational methods, many patients having been hitherto bedfast, monoplegic, hemiplegic, or spastic, have been restored to useful occupation despite large brain defects. During the Great War remarkable results were obtained in patients who had sustained large and extensive injuries to the brain and skull. Particularly so were the results obtained by the method of Cushing, which recommends early complete debridement of contused and contaminated tissues in wounds of the skull penetrated by contaminated objects. It is found to be much better to sacrifice even a moderately large area of cerebral substance than to risk the probability of a fatal meningitis.

As a rule, by gentle irrigation through a soft rubber catheter, disorganized and pulpified brain substance and bone splinters are removad, and the catheter serves as a probe for the location of bone and other foreign substances in the brain tissues, which are then removed. In less extensive cases the wound is filled with a two per cent solution of dichloramine T in chlorocazane and the opening in the scalp is completely closed. Although some wounds may heal primarily and the patients continue for months without evidence of infection, latent bacterial foci frequently remain about buried sutures, bits of bone, ligatures, and small foreign bodies. There are numerous cases of abscess and meningitis developing many months after the apparent primary healing has been reported. Therefore, in extensive wounds, grossly contaminated wounds, or wounds in which numerous ligatures and sutures are necessary where drops of pus may form about the knots of non-absorbable sutures or ligatures, one should not hasten primary closure. The persistence of infection about a non-absorbable suture is sufficient reason why it should not be buried in a wound which is not strictly aseptic.



Figure 1. General course and direction of the bar. Picture taken eighteen months after injury.

The case herewith reported represents the type of injury that includes extensive trauma to soft tissues, skull and brain substances. The treatment given this case closely followed the general outline developed during the War, except that no attempt could be made to close the wound, because of its extent, and because it was grossly contaminated.

The accident occurred approximately five years ago and the report purposely has been withheld so that the report might accurately detail the after effects.

* Presented before the section on surgery of the Indiana State Medical Association at the Michigan City session, September 29, 1932.

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Case Report: Accident occurred June 25, 1927, at 3 p. m. The patient, a man 37 years old, Lithuanian, weight 135 pounds, right-handed, and in good health, while working at the "draw bench" in a local steel mill, stooped over to pick a piece of waste material off of the machine when one of the steel rods to be drawn was accidentally started through the machine. This rod was hexagonal in shape, 26 feet long, and ⅝ inches in diameter. It entered his head just below the angle of the left mandible. The rod passed upward through the floor of the mouth just behind the left tonsil and soft palate, on up transversely through the nasopharynx and right orbital fossa just lateral to the right optic nerve, on through the base of the skull,



Figure 2. Wound of exit of the bar, showing bone defect; also showing rotation of right eye to the right after the recovery of the paralysis of the external rectus muscle. Picture taken eighteen months after injury.

through the right half of the frontal lobe of the brain, and out through the top of the skull in the right lateral frontal region, slightly posterior to the hair line. After 22 feet of this bar had gone through his head, someone stopped the machine, thus pinning him there, until he called out for help. Fellow workmen manually pulled through his head the remaining 4 feet of the dirty, scaly, oily bar. The bar was not hot, as this is a cold machine.

He was seen at the hospital within twenty minutes. Physical examination reveal him to be in severe shock. He was perfectly conscious, and not in severe pain. There was a gaping hole, one and one-half inches in diameter, under the angle of the left mandible. The great vessels of the neck were in plain view and had not been torn. One could look up into the nasopharynx very easily through the wound of entrance. The wound of exit of the bar had punched out a fragment of skull, approximately two inches square. The brain tissue and dura were badly lacerated and torn, and several small spicules of bone were embedded in these devitalized tissues. Hemorrhage was moderately profuse.

There was a paralysis of the external rectus muscle of the right eye, indicated by his inability to rotate that eye to the right. All other ocular movements were normal. There was a marked dilation of the right pupil. The left one was normal. His vision was normal. There was no deviation from the normal mentally, and no paralyses. The reflexes were normal. There were no aphasias or any other demonstrable abnormalities.

The x-ray examination, taken later, revealed a linear fracture of the calvarium on the left side at about the tempo-parietal suture. The fracture also was noted to radiate posteriorly and superiorly toward the pterion. There was noted a defect in the bone of the calvarium in the right lateral frontal region, which was the wound of exit. This loss of bone tissue was about two inches in diameter. There was also noted a linear fracture on the right side of the calvarium extending downward.

A thorough debridement was done immediately after the accident with the aid of local anesthesia. A small, soft rubber catheter was then gently passed into the right hemisphere following the tract of the bar, and immediately there escaped a considerable amount of pulpified brain tissue and blood clots. The tract of the steel bar was carefully irrigated with saline. In advancing the catheter and irrigating, it was found that the saline solution began running out of the nose and mouth, so the irrigation was immediately discontinued. There were no disturbances of the respiration during the irrigation. The entire cleansing and debridement operation, which required about one hour, was completed by placing a small rubber tissue drain down into the tract in the brain. On account of the large size of the wounds of entrance and exit it was not possible to close them. The usual treatment for shock was instituted and the patient put to bed.

The patient's condition was considered as extremely precarious, but twenty-four hours later he was no worse. His shock at no time was profound. As the days went by his general condition showed improvement. He was fed in the right lateral position to prevent liquids from pouring out of the wound of entrance. The pulse went no higher than 120 per minute, respiration 20, and the temperature 102.5 maximum. The blood pressure varied from 90/60 to 110/80.

The sinus tract through the brain was irrigated daily for several weeks with various antiseptic solutions, and smaller catheters were used as the sinus tract grew smaller. Finally a ureteral catheter was used very successfully. A few weeks after the injury, the sinus tract was carefully filled with iodipin, and X-rays were taken. It was noted that the iodipin filled the sinus tract and demonstrated the communication with the pharynx. There were no pocket formations, and the tract appeared to be about one-fourth of an inch in diameter.

The patient's recovery was uneventful and he left the hospital about six months after the injury. The right pupil had returned to normal size, gave normal reactions, the external rectus muscle paralysis cleared up, and he could rotate the eye normally. The fundi were normal, and the vision of each eye was normal.

He returned to the hospital February 24, 1928, with pain in the right ear. The mastoid was tender and the temperature was 99.6. X-ray revealed a degeneration of the right mastoid cells. The ear drained a few days and cleared up; no surgery was instituted. An audiogram taken recently showed a 73 per cent loss of hearing in the right ear.

The patient's original weight was 135 pounds. His lowest weight during the illness was 95 pounds. He now weighs 145 pounds. For the past three years he has been gate watchman at the same place where he always has worked. His wounds have remained healed. He has no sequelae except the defective hearing in the right ear.

The absolute absence of intellectual impairment in this case is gratifying in view of the extensive lesion. The excellent nursing care which this patient received during his entire illness should be mentioned as a prominent factor in his recovery.

Unfortunately, the treatment of penetrating wounds of the brain in civil life seems to have been influenced very little by the excellent results obtained through the technique employed during the war. The general conservative attitude toward the ordinary skull injury has no place in the management of a patient whose brain has been penetrated by a foreign body. A prompt debridement of the scalp and skull, with the removal of pulpified brain, blood clots, spicules of bone, and foreign bodies, should be done as thoroughly as possible to prevent infection which is the most serious menace to the patient. These operations can almost always be done under local anesthesia, and this is a great advantage.

ACUTE APPENDICITIS IN CHILDREN

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During the past summer it was brought to my attention that the death rate from appendicitis in the Mishawaka hospital was increasing at an alarming rate. A closer analysis showed that the death rate from all ages was over 11 per cent and a large percentage was in children. These cases were all ruptured, and peritonitis was present when the patient was operated. In all of these cases the patient was brought to the hospital as soon as seen by the physician and immediately operated. The most obvious explanation for this prevailing condition was that, due to the depression, the doctor was not called until the patient was seriously ill. However, we did not like to dispose of such a death rate without serious study, so the mortality statistics of Indiana as well as the whole United States were delved into. This study covered the past five years, and showed some interesting statistics.

In the whole United States the death rate in children dying from appendicitis increased 8 per cent in that term of years, while in all ages the death rate increased 13 per cent.

Illinois showed about the same results. Michigan's death rate in all ages was the same, but the deaths in children increased 22 per cent.

In our own Indiana the statistics were more alarming. In all ages the deaths from appendicitis have increased 40 per cent in the past five years, and in children from one to fifteen years of age, 64 per cent in five years. This increase is obviously not due to any economic depression, and as the medical profession must stand the responsibility it seems pertinent that we refresh our minds on the subject of appendicitis and the peculiarities of appendicitis in children. We must always be thinking of appendicitis and we must educate the public at all opportunities to the importance of an early diagnosis and an early treatment.

Acute appendicitis is said to be rare in infancy, to increase steadily up to five or seven years, and from that time to be as frequent as in adult life. Bolling, in a series of collected cases, has found that 28 per cent of all cases of appendicitis occur in patients under fifteen years of age. He emphasizes the great difference in the stage at which the disease is recognized in the first five and in the succeeding ten years. I am inclined to believe that appendicitis in infancy is not as uncommon as one would think and that its apparent rarity is because of the indefinite symptoms and the difficulty of their recognition. It is usually called colic or enteritis, and overlooked unless perforation and general peritonitis develop. We are waiting for the classical symptoms and signs and they are not always present.

The etiology and pathological processes are practically the same at all ages. Some importance has been placed on the pin-worm as an etiological factor in appendicitis in children. It is true that children with pin-worms also have appendicitis and that the pin-worm has been found in the appendix, but that does not prove that it was the cause of the inflammation. The association of tonsillitis or influenza with appendicitis is well known. It is not infrequently associated with infectious diseases, measles, acute rheumatism, enterocolitis, etc.

The symptoms and signs are modified somewhat by the anatomy in children. The cecum is relatively higher, the appendiceal opening is more funnel-shaped and the appendix relatively larger. Therefore, it drains better, but it is more likely to be peculiarly situated. The pathological processes progress faster in children and once perforated a general peritonitis is more liable to develop. In structure the coats of the appendix are comparatively thin and delicate, especially the submucous one. This accounts for the rapidity with which perforation takes place. Perforation occurs in younger children from one-third to one-half again as often as in older children.

In many cases the familiar symptoms of appendicitis,—localized pain, vomiting, fever, muscular rigidity, abdominal distention and tenderness, are all present and the diagnosis is easy. But perhaps

in the larger number of cases the disease is irregular in its onset, insidious in its course and presents great difficulties in diagnosis.

It is probable that pain is one of the earliest symptoms, as in adults, and it may be dull or colicky as in adults. Babies, while they are able to show that they have pain, are not able to show in any way where it is. Young children are often unable to tell where the pain is in the body, and even older children always put their hand in the middle of the abdomen and, if asked to locate the pain, will point to the umbilicus. Howland of Baltimore emphasizes that through fear the child may deny pain, and he adds: "The appendix is relatively long in children and the pain may be low down in the pelvis, high up in the abdomen or in the back. In a younger child it may be inferred that he has pain by constant crying and from the fact that he sleeps badly. Children, be they ever so ill with pneumonia or other febrile diseases, usually sleep for long stretches; but the child with abdominal pain will not sleep or let any one else sleep. Abdominal pain then is one of the most regular and important signs; it may suggest the disease of other structures than the appendix but it should never be passed over lightly."

Vomiting is also a fairly constant symptom. There is nothing characteristic about the vomiting. It may be persistent or paroxysmal.

Constipation is more common than diarrhea but either condition may occur. Other less constant symptoms are an unwillingness to move, apparently because motion causes pain. Pain is so commonly produced by efforts to sit up or be placed in a sitting position that the assumption of such a posture without complaint argues against appendicitis. Sometimes when the child is able to be on his feet, he limps.

The right thigh is flexed on the abdomen when lying down, there may be pain on defecation and frequent micturition. This is probably due to the irritation of the bladder by the proximity of an inflamed appendix.

The temperature is usually not much elevated. If over 103° it is probably not appendicitis. The height of the fever has no relation to the severity of the lesion.

It should be needless to say that the physical examination is usually a trying ordeal for the patient, the family, and the physician. A few minutes used in first winning the confidence of the child is frequently the basis of a successful examination. One should not roughly punch a suspected tender area but should approach it carefully and gradually. It takes all of the doctor's tact to do this and by some can be made sort of a game. Even under the best conditions, it is often very difficult to determine localized tenderness in a child. It is as difficult for them to localize tenderness as to localize pain. It is usually far easier to watch the child's face for expression of pain and tenderness than to accept what it says. It is usually not as hard to determine muscular spasm or rigidity. Even when crying, the spasm may be usually determined between cries. We should not wait for rigidity because it is a sign of peritonitis and not appendicitis. The same may be said for the palpation of a localized tumor, which occurs late in the disease. The value of a rectal examination cannot be overemphasized in eliciting localized tenderness and rigidity.

The laboratory gives definite aid. John B. Deaver said, "I have a complete blood count taken in all cases but it is the polymorphonuclear count that I lay stress on; the less experienced physician will do better if he carefully considers the blood count." The white count is usually over 10,000 and under 20,000 but it is by no means absolute. A polymorphonuclear leukocytosis of over 80 per cent is indicative of inflammation. In passing, one should remember that lymphocytes normally predominate in the blood of an infant.

Bolling writes, "The difficulty of diagnosis is inversely proportional to the age of child. When the disease is confined to the appendix or limited to a localized abscess, the general behavior and appearance of the child is often such as not to suggest serious illness. Pain, vomiting and fever are particularly difficult to interpret in children. The pain is rarely localized and we must be content with the statement that the child seemed to have abnominal cramps. Sometimes attention is drawn to the condition by the child leaning to the right when walking. Local tenderness is the most valuable of all signs. If corroborated by pain and vomiting with moderate elevation of temperature and leukocyte count, the diagnosis is reasonably sure. The absence of any one of these signs or symptoms is not sufficient to rule out appendicitis." Kennedy (Mayo) says, "Abdominal pain and tenderness are the chief warnings of trouble and when they occur in older children receive more or less prompt attention. In the younger child the tendency on the part of the parent and physician is to minimize the significance of a stomach ache and, because they do not suspect appendicitis, they delay examining for it." Howland (Baltimore) adds that, "It is not sufficiently considered with obscure diseases in the young. It may occur in the first few months, indeed even in the first few weeks of life. Personally I have not diagnosed it under two years of age. The primary requisite for the diagnosis of a disease is the appreciation that it may possibly be present." Deaver emphasized this point as follows, "In acute abdominal conditions, the appendix should be considered first, last and always." One should think of it always as it is the most common acute abdominal condition. One should consider it last if no other cause can be found. We must stress the fundamentals of sound diagnostic practice, trained senses of touch, sight and hearing. Of course, we must not neglect laboratory tests, but should rather use them to corroborate other findings.

In children the absence of some of the classical

symptoms or signs may raise doubt in the mind of the physician although usually an accurate diagnosis is possible. In children as in adults the question of differential diagnosis arises although the number of probabilities to be considered is perhaps smaller. It is to be emphasized again that the differential diagnosis is to be based on a careful history and a complete examination of the entire patient. In this way only can we avoid operation on patients who do not have appendicitis and not overlook the condition in patients who need operating. Helmholz of Mayo's continues as follows, "In making a differential diagnosis we have first to consider those conditions outside the abdominal cavity, namely, infections of the respiratory tract, prodromes of acute infectious diseases, measles, scarlet fever, typhoid fever, poliomyelitis and osteomyelitis of the femur or ilium."

Pneumonia is frequently mistaken for appendicitis. Howland writes, "In the differential diagnosis of these two conditions much can be learned from the appearance of the patient. The child with pneumonia has a flushed face, he looks really ill and is irritable and restless. Often to spare himself pain he breathes as much as he can with the diaphragm. The one with appendicitis is usually pale, he lies quietly and keeps the abdomen as quiet as possible by breathing costally. The child with primary pneumonia has a higher fever, a more marked leucocytosis and a more rapid pulse than the one with appendicitis. In pneumonia the increase in rate of respiration is out of proportion to the rate of the pulse. The situation may be puzzling on account of the really great abdominal pain and tenderness. Both these signs are rather more general than they are in appendicitis and often are higher up in the abdomen. The tenderness is frequently more severe than with appendicitis but it is so superficial and so little influenced by deep palpation as to suggest hyperesthesia. Tenderness detected by rectal examination is all in the favor of appendictis." Judd said, "I do not know whether there is any way of making an absolute differentiation. Of course, we do not like to operate on a child with pneumonia but the possibility of a suppurative appendicitis and peritonitis is much more serious."

In the prodromal stage of acute infectious disease and acute tonsillitis, the sudden onset, nausea, vomiting, abdominal pain and local tenderness make a picture that is difficult to evaluate unless one has a careful history of exposure and, in the case of measles, a leucocyte count and the probable presence of Koplik spots.

Osteomyelitis of the ilium may present symptoms that are differentiated from those of appendicitis with difficulty.

The symptoms of acute pyelitis at times resembles very closely those of appendicitis. If the appendix is situated behind the bladder there is often frequent micturition, which suggests strongly infection of the urinary tract. In pyelitis the tenderness is usually over the kidneys, but sometimes is over the ureters in the same situation as that of appendicitis. In appendicitis there is almost never any tenderness or muscular spasm over the kidneys. In pyelitis the urine of course contains pus and usually bacteria. Occasionally, however, there may be a complicating pyelitis with appendicitis. Rectal examination is usually of great help in the diagnosis.

In cyclic vomiting the history of previous similar attacks, absence of local tenderness, and a normal leucocyte count is usually distinctive. The danger in these cases is that parents may mistake an acute appendicitis for merely another attack of cyclic vomiting and call the physician only after the appendix has ruptured.

Conditions within the abdominal cavity that have to be considered are gastro-intestinal colic, mesenteric lymphadenitis, intussusception and inflammation of Meckel's diverticulum. Lee reports two cases in which operation was performed and enlarged glands found, instead of the expected appendicitis. Mesenteric lymphadenitis is described by Brenneman as giving a clinical picture identical with that of appendicitis. I have never met this condition, but if looked for it might explain some cases where appendicitis is diagnosed and a normal appendix found.

Attacks of colic are common in infants, particularly when too frequently fed. In older children there is usually some indiscretion in diet which accounts for the pain, but beware of diagnosis of a "green apple belly ache" without a most careful examination. The colic attacks are paroxysmal and usually relieved by pressure. Between attacks of pain there is no localized pain or general tenderness, no fever.

Intussusception is found most frequently when appendicitis is most seldom diagnosed, that is, in the first two years of life. The sudden onset with periodic attacks of pain, absence of fever, constipation, bloody mucus from bowels, tumor, and no local tenderness make a very characteristic picture that is not likely to be confounded with appendicitis, except late, when the invaginated bowel might suggest an appendiceal abscess. Intussusception is about the only cause of bowel obstruction in children that would have to be differentiated.

Meckel's diverticulitis produces a picture very much like appendicitis except that obstruction usually occurs with it and there is more shock and usually fecal vomiting and blood in stool. The localization of pain and tenderness is usually on the right side and up higher. In some cases one has to be satisfied with a diagnosis of "surgical abdomen."

I have been unable to find any writer who advocates any treatment other than appendectomy when the diagnosis is made. As stated before, there has been so much confusion in the diagnosis of appendicitis in children that if we wait for the classical signs and symptoms we are face to face

with peritonitis and not appendicitis. So the treatment is surgery just as soon as possible. To emphasize the above: Bolling has operated on 123 children from one to fifteen years of age at St. Luke's Hospital in New York. In the group above six years of age, abscess or contamination of the peritoneal cavity necessitated drainage in 60 per cent. In the Babies' Hospital (New York) over 90 per cent of these patients had an abscess or ruptured appendix and peritonitis when admitted.

The post-operative complications are in about the same proportion as found in adults, the notable exception being the conspicuous absence of post-operative ileus.

I had one case the past winter in which a six year old girl developed an intussusception eight days after an appendectomy. An early diagnosis was made, she was again operated. The invaginated bowel was easily replaced and it was unnecessary to resect any of the intestines. This did not recur and she made an uneventful recovery except for an otitis media.

Another little girl, eleven years old, had been having abdominal cramps for several days when I saw her first. The appendix was nearly as large as the ileum and was difficult to deliver. A peritonitis was present. Drainage tubes were left in for nine days and she was making an uneventful recovery. When the tubes were removed she started to vomit, had increased fever and obstipation. She was re-operated but was too ill to stand much surgery. Only a jejunostomy was done but an inflammatory mass could be felt at the upper left of the old wound. She recovered uneventfully until the third day when the jejunostomy catheter came out. We anticipated a recurrence of the signs of obstruction but she made a very rapid recovery.

The average stay in the hospital is eleven days, and the little patients have enormous recuperating powers after the focus is removed.

In controlling the mortality of acute appendicitis there are but two controllable factors according to Bower and Clark.

The first factor is delay. This is controlled by educating the public to call the doctor early and by educating the profession to differentiate between appendicitis and peritonitis.

The second controllable factor is the administration of laxatives. At the Samaritan hospital (Phila.) 92.3 per cent of all patients who died from general peritonitis had taken laxatives before admission. 77.4 per cent of those who entered the hospital with a diagnosis of appendicitis and local peritonitis, and 24.3 per cent of patients with a simple appendicitis, also received laxatives before admission. The public must be made aware of the danger of giving laxatives in the presence of abdominal pain.

Ochsner, whose name will ever be associated with appendicitis, in one of his last discussions of this disease and its treatment, remarked that nowadays almost any one attempted to perform an appendectomy, and, if the disease was in an early stage, with the aid of modern surgical asepsis, his surgery resulted in a recovery. When one is confronted with the complications that do occur, and there is more than a simple inflammation, then the mortality depends on the judgment, experience and skill of the operating surgeon.

In conclusion I can only say that deaths from appendicitis are increasing especially in Indiana. Many of these deaths occur in childhood and most of them could be prevented if no laxatives are given and the patient is operated early. The object of this paper is not to bring us anything new, but to remind us that children do have appendicitis and we must be on the lookout for it. By this means we can reduce the death rate.

"We must always be thinking of appendicitis and we must educate the public at all opportunities to the importance of an early diagnosis and an early treatment." There is an apparent laxity, nearly bordering on indifference, as to our attitude toward this surgical entity.

The possible reasons for the present recorded mortality resulting from appendiceal infections and inflammation and their surgical treatment merit continued discussion and study. There is a pressing need for the observance of pertinent factors that have a definite bearing on the end result and the mortality that is encountered.

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DISCUSSION

PENN G. SKILLERN, M. D. (South Bend): My interest in the essayist's subject began when, as surgical house officer at the Lankenau Hospital in Philadelphia, I reviewed 500 cases of appendicitis in children operated upon by the late John B. Deaver and his brother, Dr. Harry C. Deaver, and published by the latter in the Journal of the American Medical Association, 1910 IV, 2198-2205. Our findings, even in those days, were quite in accord with the points Dr. Graham has emphasized. In Dr. Deaver's clinic, of about twenty abdominal opera-

tions performed each afternoon, at least five were for appendicitis, so that we internes became familiar with all the phases of this disease. Dr. John B. Deaver eventually became an almost infallible diagnostician in appendicitis, and, so expert as an operator that in many of the clean cases in which I assisted him, but three and a half minutes elapsed between the incision and the last stitch.

The importance of appendicitis in children is shown by the aphorisms used by surgical teachers indelibly to impress their students. For example, the the great Finney: "In adults the tendency is to mistake something else for appendicitis; in children one mistakes appendicitis for something else." Deaver: "Look and act; do not watch and wait." And "Refinement of diagnosis may bring no other satisfaction than to be able to say at the autopsy, 'I told you so', which of course does the patient no good." Gerstley: "In young children with any kind of abdominal symptoms appendicitis should always be suspected until ruled out." Brown is so fearful of the effects of perforation in this ailment that he says, "If a surgeon hears that physic has been given he should operate, no matter what the symptoms may be."

The essayist might have called attention to the anatomic handicap of the child's omentum, which is short, delicate, often veil-like in thinness, and which after perforation offers but a feeble barrier to the spread of inflammation. It has been tritely stated that in adults the omentum is the policeman of the abdomen. In children, however, shall we say, the omentum is the policeman without billy-tapper, gun, or handcuffs?

The essayist refers to osteomyelitis of the ileum in the differential diagnosis. When in Philadelphia I operated upon two children with this malady, the diagnosis being proven by the gushing up of pus through a trephine hole made in the ilium just as oil from a newly drilled well.

Undoubtedly, as Peterson says, many cases of indigestion, colic, gastritis, gastroenteritis, acidosis, cyclic vomiting, etc., and many acute infections accompanied by abdominal symptoms (pain, vomiting, fever, etc.) are in reality instances of unrecognized appendicitis. The habit of deciding that such disorders are due to dietary indiscretions and that a physic will relieve the indigestion-colic, is responsible for many deaths. In fact, some surgeons even make the startling statement that every acute condition in childhood should be considered appendicitis until proved otherwise, and others even go so far as to say they would rather operate on a pneumonia, by mistake, than slip up on a ruptured appendix.

Perforation means purgation, but beware of the wolf in sheep's clothing in the apparent sudden improvement and well-being of the child during the period of relieved tension after perforation. There are no symptoms, but soon, with an onrush like the eclipsing moon, comes the fatal, widely spreading peritonitis. In few conditions in practice is a mistake so fatal.

The youngest child with acute appendicitis that I could find recorded was reported by Gerstley. It developed in an unborn child. How many of us would have wanted the assignment of making the diagnosis? I should like to have Dr. Graham outline for us the diagnosis and treatment of acute appendicitis in the unborn child. On delivery the baby's abdomen was markedly distended and he vomited severely the first day. The second day these symptoms were extreme. Death occurred on the third day, the necropsy revealing a perforated appendix and peritonitis.

As editor of the "Surgical Clinics" of the late John B. Murphy, I memorized among other things his five cardinal points in the diagnosis of acute appendicitis. I shall give them in the order in which they occur.

1. Generalized abdominal distress.
2. Nausea and vomiting developing within a few hours.
3. Rigidity and tenderness in the right lower quadrant.
4. Fever developing in a few hours.
5. Leukocytosis.

In children, however, only in the fewest cases do the symptoms follow this orderly sequence. For example, a six-year-old girl had had a slight stomachache for a few days. Temperature, 99°, leukocytes 6000; differential absolutely normal. In consultation a leading surgeon examined the abdomen and in view of the vague findings was not certain as to the procedure. It was decided, however, that it might be safer to open the abdomen. The operation showed a ruptured, gangrenous appendix with free pus. The child died in a few days from general peritonitis. (Gerstley.)

There appears to be a definite relationship between appendicitis and acute intussusception, and between hernia and appendicitis. Peterson is convinced that the appendix is one of the common causes of intussusception, and as regards hernia in a child, the appendix should always be suspected when a hernia gives subjective symptoms of any kind.

I have over and over again seen acute appendicitis develop in children in about a week after an attack of acute tonsillitis, nasopharyngitis, sinusitis, or other upper respiratory tract infection. Rost reported a case occurring in measles.

According to Root, every case of uncontrollable vomiting in an infant or young child should excite our suspicion of the appendix, especially if there is a previous history of such attacks.

In examining for tenderness and rigidity in children, as in adults, it is always wiser to start in the left lower quadrant and to progress gently to the left upper quadrant, then across to the right upper quadrant, and last of all, to the right lower quadrant.

In discussing local tenderness it is well to remember that the removal of the fingers may be even more painful than their direct pressure.

Finally, I want to go on record as believing that the most valuable method of examination for appendicitis is the rather trite but often neglected one of inserting the finger into the rectum and passing it toward the right ilian fossa—surely a more direct way to elicit tenderness and feel a mass.

International statistics show, indeed, that appendicitis is the most common surgical disease of young children. Sixty per cent of all abdominal operations in children are for appendicitis, and 95 per cent of all cases of peritonitis are due to appendicitis.

HENRY J. GRAHAM, M. D., closing: Answering Dr. Skillern's question, I suppose I would do as I do in my own work—I find the appendix first, then I proceed to examine, to exclude other things, and finally make my diagnosis.

The point I am trying to get over is that 90 per cent of children when they come for operation come with abscess formation—it is usually found that there is peritonitis and pus formation before you operate. That should not be. It must be some fault in our technique, and I think the reason is that gastrointestinal troubles are so common in children that we pass them over and do not think. The mortality rate is going up, and we should in some way try to prevent that.

BLOOD TRANSFUSION*

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Blood transfusion is indicated in all severe, acute or chronic secondary anemias, regardless of etiology. It undoubtedly has its greatest value in combating the acute secondary anemia which follows massive hemorrhage or shock.

While the visible blood loss of a massive hemorrhage is usually an absolute indication for blood transfusion, it is not widely recognized that an equally drastic reduction of the circulating blood volume occurs in shock. The blood loss in either case is quantitative rather than qualitative, and its severity can only be judged clinically by the lowered blood pressure, the weak, rapid pulse, air hunger and dusky pallor.[1] Anoxemia to some degree is invariably present, and its destructive effect on the central nervous system is well known.[2] Many early post operative deaths are caused by a period of relative anoxemia, and might be prevented by timely transfusion.

Intravenous saline, glucose-insulin or saline-acacia solutions are most excellent emergency measures to restore fluid volume when a suitable donor is not available.[3,4] These fluids, however, are rapidly absorbed by the tissue cells with return of circulatory depression.[5] Transfusion is well worth while following intravenous therapy even though the patient's condition has improved by the time a donor can be secured. The donated blood plasma does not so rapidly seep away into tissue spaces,[6] and the donated cells have been positively identified in the patient's circulation as long as a month after transfusion.[7] Transfusion will thus prevent the usually unobserved period of secondary depression which so often follows intravenous therapy for shock or hemorrhage.

While the sudden volume loss in an acute anemia does not immediately change the hemoglobin percentage or red cell count, the gradual loss of blood in a chronic anemia is replaced by tissue fluid. Circulating blood volume is thus maintained by dilution which lowers the red cell count and hemoglobin percentage.

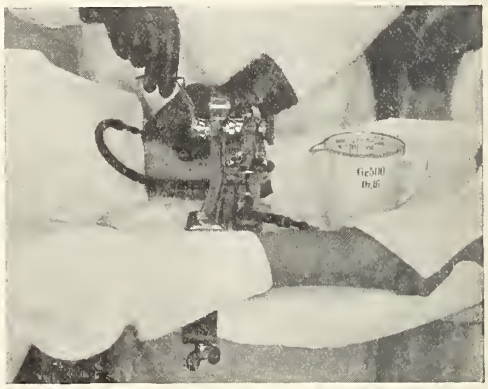


Figure 1. Head transfusion pump in use. One of the simplest and most efficient of the whole blood methods.

As restoration of volume is all that is necessary in acute anemia, one transfusion of enough blood to relieve clinical symptoms is usually sufficient. The volume necessary cannot be stated as it varies with the amount lost. As much as 1,000-1,500 c.c. is sometimes required, though smaller amounts usually suffice.

In chronic anemia, with a normal volume of dilute blood, the rapid injection of large volumes may cause circulatory embarrassment. The customary amount of 400-500 c.c. can be accommodated if given slowly, and transfusion can be repeated as often as necessary, allowing a sufficient interval for absorption of the excess fluid.

Chronic secondary anemia is not always an indication for transfusion; rather its cause must be determined and eradicated. If medical treatment is indicated and the anemia is not too severe, the various hematinics may be prescribed as a logical adjunct to conservative management. If an operation is necessary, transfusion builds up the patient's resistance and helps to prevent shock. The patient with a gastro-intestinal or genito-urinary bleeding neoplasm is almost always a victim of chronic secondary anemia. His lowered resistance to infection is usually proportional to the degree of

* Presented before the general scientific meeting of the Indiana State Medical Association at the Michigan City session, September 28, 1932.

anemia, and good pre-operative management always includes transfusion if the anemia is severe.

Prolonged convalescence after gastro-intestinal surgery may be due to slowly developing secondary anemia from mucosal oozing or slow bleeding. This type of case is also markedly benefited by transfusion, both because of the correction of the anemia, and by the definite hemostatic effect of healthy blood.

Intractable oozing of blood from the bowel in ulcerative colitis, severe nose bleed, and many other idiopathic or undiagnosed forms of bleeding may be stopped at once by transfusion, or by the intramuscular injection of whole blood. The hemorrhage of a hemophiliac may thus be arrested, or purpura hemorrhagica may be controlled and the patient

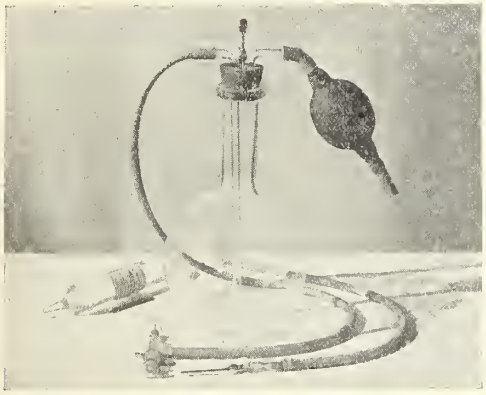


Figure 2. Simple citrate outfit. Suction pressure bulb facilitates both aspiration and injection of citrated blood.

made ready for splenectomy. Hemolytic icterus and hemorrhagic disease of the new-born may be markedly benefited by the intra-peritoneal injection of either whole or citrated blood.[8] Even though the donated blood cells migrate through the peritoneum and enter the capillary circulation unchanged, this process is too slow to be of immediate value in an acute anemia as from hemorrhage.

Deeply jaundiced patients are notoriously poor operative risks, both because of the usually prolonged clotting time and the secondary anemia. If calcium and parathormone therapy fail to reduce the clotting time to within safe limits, transfusion is doubly indicated.

While transfusion is indicated in septic patients, it has not routinely benefited them as much as might be expected. The transfusion of immune blood from convalescent donors has been used with encouraging results. If a convalescent donor is not available, a non-specific donor immunity may be quickly produced by foreign protein therapy. Transfusion four to six hours after non-specific donor immunization has been followed by remission of septic symptoms. The greatest benefit, however, has followed transfusion of specifically immunized donor's blood in subacute bacterial endocarditis and similar bacteremias.[9,10]

The toxemia accompanying extensive burns is actually due to the loss of relatively enormous quantities of plasma protein, salts and fluid. This may be effectively combatted by blood transfusion and intravenous saline in large quantities.[1,11]

Carbon monoxide poisoning is essentially a marked anoxemia resulting from the chemical fixation of hemoglobin by the poison gas. If seen early, life may be saved by immediate blood transfusion or the injection of a preserved blood-citrate-glucose mixture.[12]

Many of the protracted febrile diseases leave the patient so debilitated that convalescence is slow in spite of the usual supportive measures. In this type of case, transfusion for relief of secondary anemia provides an enormous boost after which convalescence is usually rapid.

While primary anemia used to head the list of indications, transfusion has been replaced by the more effective liver extract therapy.

Contra-indications to transfusion, such as uremia, pulmonary edema and cardiac decompensation are so obvious that their discussion is unnecessary. But there is the frequently discussed case of bleeding duodenal ulcer. If the patient is bleeding rapidly, transfusion and surgical hemostasis are usually indicated. In less severe cases bed-rest and morphine may control the bleeding.

Transfusion is not indicated by any rule of thumb, such as the blood count, hematemesis or melena. It is only one of many equally valuable therapeutic procedures and should be used only when it fits logically into the appropriate scheme of general management. In other words, transfusion should be a rational therapeutic procedure, rather than a symptomatic treatment, or a last heroic gesture to satisfy the patient's family. The majority of surgeons, however, transfuse only when necessary and then use the simplest available technic compatible with safety.

When a blood transfusion is clearly indicated the risk is negligible, as the end justifies the means. However, reactions do occur, even with the best of technic, and recently have been the subject of intensive investigation. They have been classified according to their cause as (1) incompatibility, (2) chemical, and (3) allergic. The incompatibility type of reaction, with severe back pain, vomiting and collapse was a frequent occurrence before the discovery of agglutinins and the classification of human bloods into four groups. Since the general use of grouping and crossmatching tests before transfusion, the occurrence of incompatibility reactions has been rare indeed, but none the less alarming when they do occur. As technical error in grouping or crossmatching must be blamed for this most severe type of reaction, an absolutely dependable laboratory technic is just as important as good surgical technic to the successful performance of a transfusion.

The common laboratory practice of using only group II and III sera for the typing of unknown

bloods occasionally leads to serious error. It is well known that the agglutinin content of group III serum is usually lower than that of groups II and IV, and that it deteriorates much more rapidly than other sera. A Group II prospective donor might therefore be erroneously grouped as a IV (Moss) and used as a universal donor with disastrous results. The standardization of the agglutinin content of diagnostic grouping sera, the frequent checking of these sera against known group cells, and the routine use of group IV sera as a check test in every case will avoid erroneous grouping. Cross matching is advisable as a final precaution, as the existence of incompatible sub-groups within group II is well known, and if group IV donors are used, the occasional "dangerous universal donor" may be apprehended.[14,15]

Even with the best of laboratory facilities, the surgeon should always watch for the early signs of reaction. The occurrence of back pain, paresthesias, vomiting or faintness, should warn him to stop the transfusion immediately, as the mortality of incompatibility reactions is directly proportional to the amount of blood transfused. For this reason it is a wise precaution to transfuse the first 25 to 50 cc. of blood very slowly, and ask the patient to describe any unusual sensation he may have.

Several explanations of the production of these reactions have been offered. The most plausible is, I believe, that of intravascular agglutination with lodgment of clumped cell emboli[15] and anemic infarction. If the patient survives the immediate general circulatory embarrassment, the simultaneous renal capillary obstruction may produce a fatal uremia. The observation that the necrotic renal tubules in fatal cases are surrounded by granules of hemoglobin-like material, merely presents the picture of partial hemolysis of the obstructing cells and incomplete capillary regeneration.[16]

At any rate transfusion should be stopped at once on the appearance of any untoward symptom. Adrenalin has been found useful in combatting the shock of such a reaction and should always be available.

Chemical reactions are typically less severe and usually consist of a delayed chill followed by fever and malaise. They may be caused by: (1) abnormal acidity or other chemical impurity of the sodium citrate solution; (2) improperly prepared or contaminated saline solution; (3) unnecessary cooling of the blood during its transfer; (4) the too rapid injection of blood; (5) partial clotting of blood in the apparatus; (6) contact with air; and (7) foreign material, such as the powder from the inside of new rubber tubing, the sublimed sulphur which appears in old tubing, lint or dust from improperly cleaned glassware, or even particles of glass from the filing and breaking of ampules of citrate solution.[17,18] Avoidance of this type of reaction obviously consists of the use of chemically pure sodium citrate, the preparation of protein free distilled water for saline solution, and the preparation of all instruments, glassware and rubber tubing by approved methods.

Allergic reactions are manifold in nature and may occur as an asthmatic attack or an urticarial eruption. Adrenalin is the obvious remedy in the acute attacks with ephedrin to prolong its effect.

Typical food poisoning reactions may occur when the donor has eaten some food to which the patient is sensitive, and anaphylaxis may occur if a donor is used repeatedly for the same patient.[19] Donors are therefore required to report for transfusion with an empty stomach, and are not used more than once for the same patient. Syphilis, malaria and other blood borne diseases have been inadvertently transmitted by blood transfusion. Donors therefore should have a negative Wassermann test history and physical examination before transfusion.[20,21,22]

The factors governing a surgeon's choice of technic for blood transfusion should be: (1) Simplicity and durability of the apparatus; (2) technical ease of manipulation; and, (3) allowable variation of volume and speed of injection. Transfusion literature has been largely a series of reports of new methods, each writer conveying the impression that his method should be universally adopted because of its obvious advantages over all others. The proponents of whole blood methods claim that the coagulating and other protective powers of whole blood are destroyed by citration,[23] while the citrate enthusiast believes that the very simplicity of the citrate technic and the fact that speed is unnecessary, is sufficient reason for its universal adoption.[24] It seems, however, as with many other surgical procedures, that the actual technic used is of far less importance than the skill and general experience of the operator. Statistics on incidence of reactions vary widely with the viewpoint of the author, but unbiased comparison of results has shown that with good technic, reactions occur with almost equal frequency regardless of the method used. Technical simplicity is really the most important factor in a busy surgeon's choice of a transfusion method. He will wisely avoid any method which requires trained assistants or the routine surgical exposure of veins. Transfusion is properly a one-man operation, and its technic can be performed by anyone capable of accurate venipuncture.

While the transfusion of unmodified blood is undoubtedly the procedure of choice from a theoretical standpoint, practical difficulties in the execution of most whole-blood methods usually discourage anyone but the skilled whole-blood enthusiast. The aspiration and citration of blood in a closed system of suction bulb, flask, tubing, and needle, and the injection of this blood under slight positive pressure from the same flask, is undoubtedly the simplest and safest method in general use today.

The actual technics of blood grouping, cross-matching and transfusion are not suitable lecture subjects. Rather they must be demonstrated first hand and observed minutely to be of benefit. Suf-

fice it to say that, whenever possible, I use a donor of the same group as the patient in preference to a universal donor, that I insist on crossmatching before transfusion, and that I use a whole-blood method which is technically as simple as citration and which avoids all the real and theoretical dangers of citration.[25 26]

Anyone capable of accurate venipuncture can transfuse any amount of blood at any desired rate of speed. The volume of pump, tubing and needles is only 5 c.c. Under ordinary operating conditions blood enters the patient's vein three seconds after leaving the donor, thus avoiding stagnation and early coagulative changes. The absence of valves and narrow orfices through which the blood is forced at high pressure prevents fibrin formation and sticking, so common to the syringe-valve methods.

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JOHN W. THOMSON, M. D., Garrett: I wish first to thank Dr. Stout for his concise and thorough presentation of his subject.

Transfusion of blood has long been of great interest to both the profession and the laity. Coincidentally with Harvey's discovery of the circulation of the blood, many were the suggestions as to the means and results to be obtained by transfusion. For example, it was suggested that in cases of marital infelicity, reciprocal transfusions of both husband and wife would completely smooth the rest of their life journey. When we stop to consider that it is only since 1910 that blood transfusion has been changed from a risky procedure reserved for a last resort to a safe and scientific method, it is not surprising that so many methods of transfusion have developed

I am particularly pleased that Dr. Stout has pointed out the danger of depending entirely upon blood grouping by Vincent's method, and insisting upon direct cross-matching of the blood before use. Your attention should also be called to the danger of using the same donor in repeated transfusions to the same recipient.

In regard to method, I am entirely unfamiliar with the Head pump as shown in Dr. Stout's pictures. The method seems simple and susceptible to few elements of error, and much superior to the majority of the valve and syringe devices which I have seen. It is undoubtedly superior to the complicated technique of the Kimpton-Brown tube, or the Lindeman multiple syringe method. The drawback is that you have to have the pump, and it costs real money.

For myself, I have fallen back on the citrated blood method, collecting the blood in a vacuum flask, adding the citrate solution through a thistle tube as the blood is collected, thus obviating the necessity of stirring the blood with defibrination, the injection into the recipient being made from the same container.

THE EYE SYMPTOMS OF BRAIN TUMOR*

M. RAVDIN, M. D.
EVANSVILLE

The ophthalmologist often is called in consultation by the internist or general surgeon in cases of suspected brain lesion. If we find the patient suffering from persistent headache, vertigo and projectile vomiting, if the pulse rate is slow, and the patient has mental or cerebral disturbances, and if ophthalmoscopic examination reveals double choked disc, we are justified in a diagnosis of brain tumor.

1. Double choked disc is the most important symptom in the diagnosis of brain tumor of whatever kind and wherever situated. It is the most objective sign of an organic brain disease. In about 50 per cent of cases it is one of the first symptoms, but it may be late in making its appearance, and occasionally it is the only symptom

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present until very late in the progress of the disease.

It is present in from 80 to 90 per cent of all cases diagnosed as brain tumor. It is rare in tumors of the frontal lobe, but more constant the farther back the tumor lies.

2. The ophthalmoscopic picture of the fundus change enlightens us as to the character of the disease, but not as to its nature or location. In other words, the ophthalmoscopic picture of double choked disc, pointing, as it does, to pressure within the brain, leaves us in doubt as to the nature of the tumor. It may be a glioma, sarcoma, tubercle-cyst, an aneurism, or a gumma. It may be cortical, subcortical, basal, or in the meninges.

The localization of the tumor must be attempted from the general and focal or signal symptoms present. These include, among others, palsies of various muscles, including the ocular, and the associated movements of the eyes, contractures, ataxia, areas of anaesthesia, hyperesthesia, or parasthetic disturbances of special senses, as hearing, taste and smell, trophic disturbances, et cetera. Neither the rapidity of the growth of the tumor, nor its size, has any influence on the development of the choking of the discs. It may appear early with small, slow growing tumors, and late in rapidly growing ones. The above fact, concurred in by all authorities I consulted in the literature at my command, is nevertheless open to serious question. In view of the fact that choked disc or papilloedema is supposed to be due to increased intracranial pressure, and not to true inflammatory changes, it seems to me that rapidly growing tumors ought to be evidenced by an early appearance of edema in the nerve head.

In unilateral choked disc, we direct our attention extra-cranially. We look for trouble in the orbit, the post ethmoidal cells and the sphenoid sinus. If the brain tumor syndrome is present with unilateral choked disc, the tumor is, in most cases, on the same side as the affected nerve head.

In cases of optic atrophy on one side and choked disc on the other, the tumor may be on the side of the atrophy.

In bilateral choked disc, more intense on one side, the side of the most marked fundus change is probably the side of the tumor. Intense bilateral choked disc coming on very early, and associated with vertigo and nystagmus, points to the cerebellum as the location of the neoplasm.

3. Choked disc is sometimes observed in diseases other than brain tumor; for instance, in cerebral and cerebellar abscesses, after profuse hemorrhages, in albuminuria, in diabetes, in thrombosis of the cerebral sinuses, in acquired hydrocephalus, in meningitis and in multiple sclerosis of the brain. These facts do not diminish the importance of choked disc as a classical symptom of brain tumor. It only requires careful observation and consideration of the concomitant symptoms present and they, with a careful history of the case, blood examination, Wassermann reaction, and urinalysis, will clear the diagnosis.

4. The subjective testing of the visual acuity has no value whatever in the diagnosis of brain tumor, for even a high grade of choked disc may not at first impair the vision materially, while diminution of sight, if found, may be due to errors of refraction or intraocular disease not involving the optic nerve. Hence the importance of ophthalmoscopic examination of the fundus of the eye. This little eye mirror is the umpire in settling the question of the presence or absence of edema of the nerve head.

5. While visual acuity may be very little impaired in the first stage of choked disc, it diminishes rapidly as the case advances, especially in the very malignant type of tumors. The field of vision becomes concentrically contracted with enlargement of the blind spot, and ultimately (if the patient lives long enough) complete blindness will develop from optic atrophy. The only exception to this is neuritis optica, caused by syphilitic gumma of the brain, which is early recognized and actively treated. In such cases the neuritis will subside and leave a sound optic nerve and good vision.

In exceptional cases of cerebral tumor the pathology in the optic nerve is of a low type, hence it is important for the observer not to mistake for organic change the blurring of the outline and apparent distortion of the optic disc in high degrees of hyperopia and astigmatism, a condition also having headache and occasionally vertigo and vomiting in its train of symptoms.

6. Temporary total loss of sight is another important general symptom of brain tumor. It is less frequent than choked disc, but it may be associated with it. It does come on in the early stages of the growth. The total blindness comes on suddenly and lasts from a few seconds to a minute or more. In the intervals the vision is as good as before. The patient may be able to read fine print, and his distant vision will be found normal, or nearly so. Errors of refraction are excluded, of course. These attacks are probably due to some disturbance of the cerebral circulation affecting the function of the visual centers, or they may be due to a sudden increase of the cerebrospinal fluid in the third ventricle by which pressure on the optic commissure is brought about.

Mechanism of Choked Disc. Von Graefe's original opinion was that choked disc was due to compression of the cavernous sinus with consequent obstruction of the return flow of blood from the retinal veins. In 1869 Saseman demonstrated that the outflow of the ophthalmic vein takes place mostly through the posterior facial vein and pressure on the cavernous sinus can produce only transient engorgement of the retinal veins. Von Graefe's theory was then abandoned. Stelwag and Manz, in 1865, demonstrated the distention of the sheath of the optic nerve in choked disc, produced by brain tumors. Schwalbe demonstrated, in 1869,

that the subvaginal space around the optic nerve is continuous with the subdural space around the brain, and the so-called transport theory was then advanced, i.e., that choked disc arises from the entrance of fluid into the subvaginal space of the nerve from the corresponding space in the brain, and that edema of the intraocular extremity of the nerve head takes place. Schmidt Rimpler suggested that choked disc was due, in part at least, to the irritant nature of the fluid distending the lymph spaces of the nerve. Leber held that brain tumors cause secretory inflammation and dropsy of the cerebral ventricles, and their products act at the intervaginal space as an inflammatory irritant and give rise to choked disc. Deutschmann, a pupil of Leber, held similar views and in 1887 he proved the correctness of his teacher's theory. He produced typical choked disc, with pronounced inflammatory findings, by the introduction of tubercular material into the cranial cavity of an ape, while injection of sterile agar did not produce a choked disc.

Knies says: "Anatomical demonstration in man proves positively that choked disc of tumor of the brain begins as a pure edema of the intraocular end of the nerve without any sign of inflammation. At a later period interstitial inflammatory changes may be found in the specimen, but in some cases such changes are absent at all stages." In combating Deutschmann's inflammatory theory, Knies further says: "What argument is furnished by the introduction of tubercular matter into the cranium when compared with numerous accurate anatomical examination of the human subject? In the former event purulent tubercular meningitis develops, and, as happens so often, leads to true optic neuritis, which may be associated with some swelling."

Such experiments prove nothing whatever with regard to typical choked disc of brain tumor.

Since 1909, when I had my first brain tumor case to study, I have spent much time in consulting neurological and neuroophthalmic literature with a view to ascertaining how constant are eye symptoms present in tumors of certain brain localities, and how much we can rely on the eye symptoms as localizing sign posts. I confess that as yet I have not found the way clear nor the sign posts definite.

It is in rare cases that a brain tumor can be accurately located from the eye symptoms alone, because the conditions are too complicated and the accurate localization very difficult. However, the team work done by American and European neurologists and ophthalmologists, in recording accurately the symptomatology of observed cases, and the operative or post mortem findings, has given the student of neuroophthalmology some basis for orientation. Of all writers on neuroophthalmology, Paul Roemer, to my mind, approaches the subject in a way that is at once novel, interesting, and helpful. He divides the subject of brain tumor localization from eye symptoms as follows:

1. Portions of the brain in which a tumor causes no eye symptoms.

2. Portions of the brain in which a tumor causes ocular symptoms that at least deserve notice.

3. Portions of the brain in which a tumor causes eye symptoms that have a diagnostic or localizing value.

I can only in the briefest manner scan his lectures.

Portions of the brain in which a tumor causes no localizing eye symptoms (aside from choked disc, which is a general symptom) are the central convolutions, the frontal portion of the brain, in the region of speech, in the corpus callossum in the cerebral ventricles.

The symptoms produced by tumors of the central convolutions are those of Jacksonian epilepsy; spasms at first, later monoplegias and hemiplegia; no eye symptoms. Ocular symptoms may be said to be absent in tumors of the right and left temporal lobes, the region of speech, "which includes the left third frontal convolution, the Island of Reil, the posterior end of the first temporal convolution, parts of the angular gyrus and many subcortical association tracts.

Portions of the brain in which a tumor causes eye symptoms that at least deserve notice.

In tumors of the parietal lobe, isolated oculomotor paresis on the same side, or on the opposite side, may occur from compression of the oculomotor nerve at the base of the brain or of the corpora quadrigemina.

Frontal tumors, growing towards or originating in the base, can exert pressure on the optic nerves, chiasm and optic tract, and so produce unilateral choked disc and hemiopia.

Acoustic tumors, usually called tumors of the cerebello-pontine angle.

The illuminating sign post in these neoplasms is the disturbance of equilibrium, the ataxias, central deafness, paralysis of the facial nerve and perhaps involvement of the trigeminus. The eye symptoms are subordinate; oculomotor paralysis is rare. The abducens may become affected in one or both eyes. Paresis of the lateral association of the eyes seldom occurs.

Portions of the brain in which a tumor causes eye symptoms that have a localizing value.

Tumors of the crus cerebri or cerebral peduncles. These are, as you know, a pair of bands which connect the pons and the oblongata with the cerebrum.

If a patient has paresis of all or of some of the muscles of one eye, supplied by the third nerve, associated with hemiplegia of the opposite side of the body, we can locate the tumor in the cerebral peduncle. The above combination of symptoms is called hemiplegia alternus oculomotoria or Webers symptom complex.

If the lesion is in the leminiscus, the eye symptoms may be associated with ataxia and the hemiplegia absent.

If all the muscles supplied by the third nerve are affected, the lesion is likely to be in the median part; but if the inner eye muscles are functioning, the lesion is in the spinal portion. If disturbances of sensibility are added to the other symptoms, the lesion has extended to the tegmentum. In very rare instances cases have been observed exhibiting bilateral oculomotor paresis and paraplegia, indicating that the tumor has extended to the other side.

Tumors of the corpora quadrigemina.

If there is present bilateral oculomotor paralysis, and more especially if the associated movements of the eyes up or downwards are paralyzed and the patient has central deafness of one ear with impairment of equilibrium in standing or walking, the tumor is probably in the corpora quadrigemina.

Paresis of the lateral associated movements of the eyes almost never occur, contrasting sharply with the fact that in pontine tumors it forms a most prominent symptom.

Foster summarizes the symptoms of pontine tumors thus:

Hemiplegia on one side with paresis of the external rectus or of the facial muscles on the other locates the tumor probably in the pons, on the same side as the paretic nerve. If the external rectus is paralyzed, the lesion is supposed to be in the pyramidal tract at a place through which the roots of the abducens pass. If the eyes cannot turn past the middle line of one side, the tumor involves the abducens nucleus on that side. In other words, the eyes cannot turn towards the side of the tumor. The paralysis of associated lateral movements of the eyes may be the only eye symptom present in addition to choked disc or it may be combined with loss of convergence. Paralysis of both sides of the body with eyes fixed in the median line, unable to turn to either side, indicates that both sides of the pons have been invaded by a tumor.

Tumors of the cerebellum betray themselves very often by positive symptoms as follows:

Cerebellar ataxia, well marked and appearing early, the patient staggers like a drunken person.

Dizziness—The patient feels as if objects revolve about him or he himself is revolving in space.

Divergent strabisms.

Twitching of the eyes. (Nystagmus.)

Paresis of the associated lateral movements of the eyes.

The eyes cannot be turned to the left if the tumor is on the left side of the cerebellum or to the right if that is the affected side. Anesthesia of the cornea is a symptom mentioned by Oppenheim, which may be the first sign of trigeminal involvement in connection with tumors of the cerebellum. Unilateral central deafness must be mentioned in this connection as being a valuable sign, pointing to the side of the cerebellum affected. It is present when the tumor is pressing on the cerebello-pontine angle.

Choked disc is an early symptom and as a rule is intense in character. It is produced by internal hydrocephalus due to an occlusion of the aqueduct of Sylvius.

Tumors of the base of the brain produce eye symptoms of great importance and it is in this class of tumors or other lesions that the ophthalmologist can contribute towards their localization materially. Tumors of the anterior fossa are rare. If present, they may break through the orbital roof and cause paralysis of the eye muscles, oxopththalmus, blindness of one eye, supra orbital neuralgia, sometimes anesthesia of the cornea and conjunctiva —in fact, the same symptoms as produced by a primary orbital tumor.

Tumors of the middle fossa produce eye symptoms that are very characteristic, because the chiasm, optic tracts, the nerves of the ocular muscles and the trigeminus lie in this region.

Tumors of the sella turcica which come from the periosteum or from the sphenoid sinus cause very characteristic symptoms. If situated in the median line, they cause bitemporal hemiopia. If the hemiopia appears suddenly and then disappears, we are probably dealing with a gumma. If the tumor extends forward on one optic nerve, one eye is rendered blind with temporal hemiopia of the other eye. If the tumor involves one optic tract back of the chiasm, lateral homonymous hemiopia of the opposite side is produced; should the sellar tumor grow larger and encroach upon the lateral portions of the middle fossa, paresis of the ocular muscles and trigeminal disturbances, such as neuro-paralytic keratitis, are added. Ptosis may be the first sign of oculomotor involvement. Choked disc may be absent, but instead hemiopia followed later by optic atrophy.

Tumors originating in the lateral portion of the middle fossa, and growing medialward, produce the following eye symptoms:

Neuro-paralytic keratitis.

Abducens trochlear and oculomotor paralysis. Such a tumor may extend forward and invade the orbit producing exopththalmos and also invade the othmoid cells. A case like this was in our care for a number of months and I had the opportunity to observe it from the appearance of the first symptoms until after death when autopsy revealed the nature and site of the tumor.

Tumors of the hypophysis produce at first the same symptoms as those in the sella turcica. The nearby optic chiasm is particularly exposed to injury and disturbances in the visual function are common. The most characteristic is bitemporal hemiopia. There may be blindness of both eyes from complete destruction of the chiasm or unilateral blindness with hemiopia of the other eye. Choked disc is absent; instead we find pallor of the nasal half of the discs. Paralysis of the ocular

muscles from pressure of hypophysial tumors is also possible and involvement of the ophthalmic branch of the trigeminus. Tumors of the hypophysis sometimes cause a specific symptom, namely, acromegaly. We may also have obstinate somnolence, polyuria, with polydipsia and occasionally glycosuria and intermittent flow of clear cerebrospinal fluid through the nose.

Tumors of the posterior fossa cause complicated ocular symtoms in as much as they may originate from the cerebellum, brain stem or the nerves at the base of the brain. This is the reason why their point of origin frequently cannot be determined clinically from the eye symptoms alone.

Hemiopia or hemianopsia.

Hemianopsia means blindness of one-half of the visual field. It is of several varieties. The terms employed in designating them refer to the field of vision from the patient's viewpoint, not the retina. Thus, when we speak of left temporal hemianopsia we mean that the outer or temporal half of the field of vision of the left eye is wanting, due to loss of function of the inner or nasal half of the left retina.

If corresponding halves of the field are wanting, both right or both left, the hemianopsia is termed homonymous or lateral. If both temporal halves or both nasal halves are affected, it is called heteronymous. If the superior or inferior halves of the field are wanting, it is called horizontal.

Hemianopsia is complete when the entire half of one or both fields is wanting or incomplete when a portion only of each field is wanting, the defect usually being in the form of a quadrant.

Hemianopsia is absolute when all three functions of sight as perception of light, of color and of form are wanting, or it may be relative if one or two of the visual functions are wanting.

The rare cases in which hemiopia is present for color only, are due to damage of the color center situated in the occipital lobe of the brain and are described under the name of hemiachromatopsis.

To determine the presence of hemianopsia and its extent accurately, a perimeter must be used, but it can be roughly determined without.

Hemianopsia is a valuable localizing sign, but has no value whatever in the determination of the nature of the disease, for it may be due to hemorrhage, softening of the brain and tumors, hence the nature of the lesion can only be diagnosed from the history of the case and careful analysis of the associated symptoms. The localizing indications of the various forms of half blindness are as follows:

Unilateral nasal half blindness (an extreme rare occurrence) indicates a very limited lesion, perhaps a small tumor or gumma at the outer angle of the chiasm.

Binasal emianophsia or blindness of the nasal half or both fields (also extremely rare) would indicate two symmetric limited lesions on both outer angles of the chiasm. Bitemporal or blindness of both temporal halves of the visual fields is produced by a lesion situated at the anterior central portion of the chiasm. Wier Mitchell reported a case of bitemporal hemianopsia. The central vision in his patient was 6/60 with normal movement of the eyes, normal pupillary reaction and normal sense of smell. There was atrophy of the nasal side of each papilla. At the autopsy a tumor the size of an orange was found to have produced absorption of the sella turcica and the optic chiasm was burst asunder in the middle line, each tract being directly continued into the optic nerve of the same side.

Right or left lateral or homonymous hemianopsia or blindness of the right or left halves of both fields is significant of a lesion situated at some point on the visual pathway between the chiasm and the cortical center in the occipital lobe.

The situation of the lesion is on the opposite side from the defective halves of the visual field. A differential diagnosis between lesions in the cortical center for vision and one in the optic radiations may perhaps be made. With lesions in the optic radiations may perhaps be made. With lesions in the optic radiations visual hallucinations might be present but not with cortical lesions. With cortical lesions the patient is not conscious of the defect in his visual fields, while with lesions of the optic radiations or tract the patient is conscious of the defect. There is a subjective sensation of darkness in the defective part of the visual field.

To determine if the lesion lies between the chiasm and corpora quadrigemina, the hemianopic pupil reaction of Wernicke may be of service if the reaction can be observed. A beam of light may be thrown upon the blind half of the retina and the resulting reaction of the pupil noted. If the pupil does not react, it proves that the reflex arc between the optic tract and the nucleus of the third nerve is injured, and the tumor must be anterior to the quadrigeminate body. If the pupil does react, then the lesion is posterior to the corpora in the internal capsule optic radiations or cuneus itself. With tumors in the medullary substance, other paths than that for vision may become implicated and collateral symptoms may be present, such as mind blindness or work blindness and visual aphasia with tumors in the left hemisphere. We may summarize the localizing indication of hemianopsia as follows:

If a patient having hemianopsia has no motor or sensory symptoms, but is unable to recognize or name correctly familiar objects when he sees them, although he is able to do both by means of his other senses, or if he has such psychic trouble as alexia, or color amnesia, we incline to locate the lesion in the optic radiation outside of the cuneus. When sensory disturbances appear, we locate the lesion farther forward until, where there is hemianaesthesia of one side of the body perhaps with attaxic movements, but with no distinct paralysis, we place the lesion in the optic thalamus.

When motor symptoms are present, we are guided still farther forward until, when the pa-

tient has both hemianaesthesia and hemiplegia, we look for the lesion in the posterior part of the internal capsule.

From this point forward the anaesthesia diminishes and hemiplegia with little or no diminution of sensitiveness of the skin suggests the region of the middle lobes of the brain.

Mind Blindness. This symptom was first observed by Munk in his experiments upon animals. It is also observed in man. It consists in loss of the faculty to recognize familiar objects while the power to see them continues. Patients so afflicted will not recognize by sight members of their family or friends, but will recognize them by their voice.

There are two forms of mind blindness: the cortical or subcortical. In the cortical form, the lesion is said to be in the center for memory and the patient has lost the power of visual imagination and he cannot describe objects from memory. In the subcortical form, the connecting pathway between the actual visual centre and the visual memory centre is interrupted; the patient can describe an object from memory, but does not recognize the same object when looking at it.

The lesion causing mind blindness is either hemorrhage, softening of the brain or brain tumor. If due to hemorrhage it appears rather suddenly. The situation of the lesion has been found to be in the occipital lobe, sometimes involving the parietal convolutions.

Word Blindness or Alexia. This term is applied to an inability to understand written or printed characters, although the written or printed words or letters are seen. Other objects are seen and named correctly. To an American or Englishman who is word blind, the written or printed words of the English language are like those of an unknown foreign tongue. The patient will write from dictation, yet cannot understand what he has written nor can he copy written or printed words. He understands the meaning of spoken words (he has no word deafness), he understands the use of objects around him and recognizes everybody he knows and everything familiar (he has no mind blindness). He may recognize a few letters with great difficulty. This is pure word blindness or subcortical alexia. When combined with the inability to write from dictation, it is cortical alexia. The lesion responsible for this phenomenon was found in the left occipital lobe and where alexia was complicated by agraphia (inability to write) the lesion was found in the centre for visual memory for words, which in right-handed people is situated in the left angular gyrus and inferior parietal lobule.

Visual Aphasia. Consists of the inability to name objects seen, the use of which is known to the patient; he will name them correctly if allowed to feel the object, even with closed eyes. In the few cases of visual aphasia recorded, right homonymous hemianopsia was also present. Word blindness and agraphia sometimes coexisted.

B. W. EGAN, M. D., Logansport: Dr. Ravdin has presented a very comprehensive resumé of the eye symptoms of brain tumor. I have not seen, in my search for information on this subject, any such comprehensive article under one heading as he has given us. You will recall that Fuchs' book, which we regard as the Bible of the eye, has something like one and a quarter pages devoted to a discussion of eye symptoms in brain tumor. Dr. Ravdin has given us, briefly, everything we may expect to find in the eye where there is brain tumor. I shall confine my remarks to the phase of diagnosis and the wide variance and inconsistencies of eye symptoms in brain tumors.

Lillie says: "Tumors of the brain are neither precise nor consistent in the phenomena they produce. The classic combination of headache, vomiting and choked disc, indicative of brain tumor, may appear only in part or may be absent."

Loyal Davis says: "The time has passed when headache, papilloedema and vomiting must be awaited before the diagnosis of an intracranial tumor may be made. Though no instruments or laboratory aid can equal in importance an exact detailed history of the symptoms in chronological order, and the careful evaluation of all physical signs, several important diagnostic methods are available. Daily, one is dependent on the ophthalmoscope and the perimeter to aid in establishing a diagnosis. Improvement in Roentgenography enables one to confirm a clinical diagnosis of the nature and precise situation of the lesion by the demonstration of shadows of the tumor or bony changes."

Some few years ago a case was sent to me with symptoms of headache and sinusitis, which the doctor had treated during the winter with no relief. Having had the diagnosis of sinusitis already made, I began to look him over, but was unable from his symptoms, subjective and objective, to find any sinus involvement. I sent him to the X-ray room to see what would show regarding the sinuses, but the pictures proved absolutely negative as to sinus involvement. But, in looking over the pictures further, we were struck by some pathology around the sella. We thought we could make out a shadow in that region. As the patient was suffering, and wanted to go home in spite of our advice, we permitted him to go home with the understanding that he would return in a day or two for further checking up. There were no signs, ophthalmologically, except some haziness of the disc, and very little disturbances of vision. Three days later he came in with, apparently, almost total loss of vision, and the ophthalmoscope at that time revealed complete choked disc on either side with hemorrhages, yet nothing of that kind appeared three days previously. We at once advised the family physician that in our opinion it was brain tumor, and that

night he was sent to Johns Hopkins. The next morning he was unconscious. He was put on the table and a decompression done to relieve the situation, but he did not rally from the anaesthetic, and within twelve hours was dead.

Another case, a boy seven years old, illustrates the point of prolonged illness with vague symptoms. This boy was first seen in January, with some intestinal disturbance, from which he seemed to recover. About February 9th he had a return of his headaches, and some blurring of vision of the left eye. This increased until February 11th, when I was asked to see him to interpret the meaning of his visual symptoms. The ophthalmoscope at that time revealed haziness only in the left eye, nothing more; no hemorrhage, certainly no elevation of the disc. Being unilateral I at once thought of focal infection, and had an X-ray taken, but nothing was seen; the sinuses apparently were negative; the nose was negative so far as subjective symptoms were concerned. There was some infection around the teeth, and he was advised to have that given attention. The right eye was negative. About December 25th he began to have blurred vision in the right eye and papilloedema was noted. His vision began rapidly to fail in that eye until March 1st, when he was advised to consult a neurosurgeon in Chicago. After looking him over in consultation with the neurosurgeon, internist and Roentgenologist, they ventured the opinion that it was a lesion of the chiasm, the nature of which they were unable to state. On March 8th an osteoplastic flap was turned back, and when the subarachnoid space was opened about the chiasm, an enormous amount of cerebrospinal fluid escaped under pressure. The arachnoid about the chiasm was greatly thickened, the vessels on the surface dilated, the chiasm enlarged and swollen, and the right optic nerve was three times its normal size; the left I think about one-half that size. A diagnosis of glioma of the chiasm, inoperable, was made. The wound was closed, the child taken to his room, and the family was told that the result would be fatal—that he might live six weeks, certainly not longer than three months; but the patient refused to die. Instead, he promptly got well. I have seen him many times since, the last time two days before writing this report. He is now eleven years old. His vision improved, his fields began to clear up, and so did the nerve. When last seen his right eye had 20/30 vision. He has 20/40 vision in the left eye, with a corresponding improvement in the fields, but some nerve involvement remains on that side. Otherwise, he is perfectly normal and doing the full amount of school work. Last May this boy's father was operated by the same surgeon for brain tumor. Whether it is hereditary I do not know, but, if so, the father inherited it from the boy. However, it seems from the history that the father's trouble was from an injury fifteen years ago.

In conclusion, there are frequent deviations from the hard and fast rule. The appearance of the optic disc may vary from slight haziness of the margin to a frank oedema, and careful study is necessary to interpret correctly the importance of a departure from normal. Pressure is often capricious in causing a galaxy of symptoms, and is responsible for much confusion. Thus it is necessary to correlate ophthalmologic, neurosurgical and general symptoms in a deliberate manner before a definite diagnosis or localization can be made.

J. R. GILLUM, M. D., Terre Haute: The average oculist is inclined to neglect central brain tumor symptoms and leave them too much to the neurologist. I think a paper of this sort calls attention to a great many symptoms that the oculist will come in contact with before anyone else, and he should have knowledge sufficient to recognize the importance of these symptoms. Farther than that he should not go; he is encroaching on the field of the neurologist. I do not think an oculist can be a neurologist. If he is, he is taking too much territory. I think the oculist should have a great many things at his fingers' ends. For instance, a patient comes in with optic atrophy. If he cannot explain it by physical examination or the symptoms in the eye, the patient should be referred to a neurologist. If he comes in with an ocular palsy and the oculist cannot demonstrate definitely that the palsy is of orbital origin, he should refer the patient to a neurologist. He ceases to be a patient for the oculist and becomes a patient for the neurologist.

I am sorry that more was not said about perimetric findings. It is my opinion that the perimetric findings are present much earlier in choked disc than the ophthalmoscopic findings in papilloedema or optic atrophy. It is very difficult to tell whether a patient has a beginning atrophy. The sense of vision in using the ophthalmoscope is not the same in all doctors. One may say the disc is slightly pale, the edges clear cut; another may say that in his opinion it is normal. It all depends upon the keenness of the man using the ophthalmoscope. Using the perimeter, I think, will give more definite knowledge.

LARUE D. CARTER, M. D., Indianapolis: The majority of brain tumor cases are first seen by the ophthalmologists or otolaryngologists; they report to the ophthalmologist on account of defective vision, diplopia or some other condition pertaining to the eye; they report to the otolaryngologist on account of persistent headache or dizziness, with the idea of sinus infection or some other pathological condition about the nose or throat. I do not believe we could possibly make much headway in the study of brain tumor without the aid of the eye experts. It is true that in certain tumors, as Dr. Ravdin pointed out, we have no eye symptoms. Certain tumors may go through the whole course without ocular symptoms, but 85 to 90 per cent will show some change around the disc, a con-

traction of the field of vision or some disturbance of the oculomotor group of muscles.

An interesting thing mentioned by Dr. Ravdin is that in frontal tumors we may sometimes get a greater degree of choking on the contra-lateral side. Lillie explains this finding by showing that a frontal, fronto-temporal or fronto-parietal tumor may, by pressure, more or less obliterate the ipso-lateral ventricle, thus making pressure on the contra-lateral foramen of Monroe, producing an internal hydrocephalus on the opposite side, with consequent choking of the contra-lateral disc.

Another phenomen occasionally associated with frontal and temporal tumors is the disturbance of lateral and vertical movements of the eye. It is often difficult to connect this disturbance with the peripheral portion of the oculomotor nerve, but it has been amply demonstrated that in the third frontal and third temporal convolutions there are cortical centers for the oculomotor nerves, which explains their involvement in this type of tumor.

Choked disc simply means increased intracranial tension; it does not indicate the size of the tumor or its location. A small tumor blocking the aqueduct of Sylvius may produce much greater disc swelling than a much larger tumor in a socalled silent area.

Not long ago I saw such a small pedunculated tumor of the third ventricle, which floated into the aqueduct of Sylvius, acting as a ball valve. At times there would be terrific attacks of headache with a rapid swelling of the disc, which would clear up after a few days; the increased intraventricular pressure evidently being sufficient to float the tumor away from its lodging place. The patient finally died in one of these attacks and the tumor was found, firmly fixed, in the aqueduct.

After all, the diagnosis of brain tumor and its localization depends largely upon careful history-taking, the chronological order of the appearance of symptoms and neurological signs. The X-ray may show a tumor shadow, but such fortunate occurrences are rare. Erosions of the clonoid processes and increased convolutional markings are helpful, but by no means conclusive. Ventriculograms and encephalograms have a wide field of usefulness, but they have not solved the problem of the diagnosis of cerebral neoplasm. Spinal fluid pressure readings and laboratory studies of the spinal fluid add to the general information.

It is only by a correlation of history, neurological signs, X-ray and laboratory findings, together with the co-operation of the ophthalmologist and otolaryngologist, that a positive diagnosis can be reached, and we all know how often such conclusions are fallacious.

MARCUS RAVDIN, M. D. (closing): The point taken up by Dr. Carter in his discussion, namely, attacks of blindness which come on suddenly and disappear, is also covered in my paper. Dr. Gillum mentioned the opening of the posterior ethmoid and sphenoid cells in retrobulbar neuritis. Personally, I have no great objection to that procedure, but I know of a case where the opening and curetting of a posterior cell resulted in sudden monocular blindness which was permanent. You can visualize the close proximity or relationship between the optic nerve on the one hand and the posterior ethmoid cells and sphenoid sinus on the other. Sometimes one large posterior ethmoid cell takes the place of the sphenoid on that side and the optic nerve is almost exposed in that cell. The slides at the conclusion of my paper showed the relationship very beautifully. For that reason I am very careful not to curette the posterior ethmoid cells. I uncap the cell but do not curette. I have a specimen in my collection, given to me by Dr. Mosher, in which the internal carotid artery is exposed in the sphenoid sinus and only separated from the cavity by the mucous membrane. Retrobulbar neuritis is really not a subject for discussion here, but since Dr. Gillum mentioned it I will say that retrobulbar neuritis is not always due to accessory sinus disease.

CLINICAL VARIATIONS IN THYROID SURGERY

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There are many variations in the clinical picture presented by patients with thyroid disease. In fact, the typical text-book case is almost an exception among a large number of cases. A consideration of the variations most often met with assists in diagnosis and is important from the standpoint of treatment and prognosis.

The most common variant in thyroid disease and the one most often unrecognized is the mild chronic case with slight gland change. These patients have a metabolic rate so little elevated that it is covered by the quotient of error in estimation. They are semi-invalids and are usually considered to be neurasthenic or hypochondriac. Fatigue and inability to work and carry on in a normal manner is the outstanding symptom. Tachycardia may not be present when at rest, though the pulse rate is too volatile. Careful palpation of the gland is the key to diagnosis. The value of the recognition of the slightest diseased change in the gland substance by palpation has never been sufficiently emphasized. It is more accurate in a clinical way than is the microscopic examination of the tissue. A normal basal metabolic rate or one on the minus side does not exclude toxic thyroid disease.

When complications arise they frequently overshadow the symptoms which are the direct result of thyroid intoxication, and they always add to the difficulties and gravity of surgery. Most of these make the patient a poor surgical risk. A few add to the danger of surgery by increasing the technical difficulties of thyroidectomy. The

most important one of these is strumitis. Nodular goiters when carried for years may become inflamed. The patient then is in a precarious condition as toxic symptoms appear and asphyxia supervenes. The trachea ordinarily escapes from pressure in the largest of goiters, but when there is inflammation present the trachea becomes fixed and swelling quickly causes compression.

A goiter in which there has been repeated attacks of inflammation becomes so adherent that its removal is tedious and difficult. It took two hours to dissect out a small adherent goiter which could have been removed easily in thirty minutes if not adherent.

When the goiter is large and widely spread, adhesions may even make it inoperable. Most intrathoracic goiters come out of the chest easily, but if adherent from strumitis all adhesions must be separated and there is danger of tearing the pleura.

Malignancy acts in the same manner to produce asphyxia by fixation and compression. The incidence of malignancy and of strumitis should be presented to a patient with a nodular goiter as they both may become fatal complications.

The technical side of thyroid surgery has reached a point where tetany and injury to the recurrent laryngeal nerve are both extremely rare. Unusual involvement of the posterior portions of the lobes by nodular growths may make it necessary to disturb the parathyroids. In large intrathoracic goiter on the left side there may occur stretching of the recurrent laryngeal nerve during delivery, causing laryngeal spasm and requiring tracheotomy, with laryngeal paralysis for several months after operation.

The physiologic activity of the thyroid gland is related to that of every other organ in the body. Therefore, it follows that when the thyroid gland becomes diseased, if there is any other disease present, a complication results regardless of which may be considered the primary trouble.

It is our purpose to take up the common and important conditions which we have found associated with more than two thousand operated thyroid cases. This is not a statistical summary, although it may seem advisable to indicate the frequency of certain conditions. First to be considered are those which arise from the presence of inflammations of various kinds in a hyperthyroid patient. Thyroid patients easily contract infections and the clinical evidences of infection are increased by the presence of thyroid disease. Also any intercurrent infection adds to the severity of an hyperthyroid state. In the presence of chronic focal infections, such as diseased sinuses, it is often impossible to get a good result after operation unless the infection is eliminated. This is a synergy and not cause and effect, for thyroid disease, once established, ordinarily will not get well from having the focal infection removed.

The presence of thyroid disease in patients with pyorrheic mouths, infected, bleeding gums and characteristic breath is met with in case after case until one unconsciously begins to think that thyroid disease is a result of oral sepsis, though we cannot prove such to be true. In mild chronic thyroid disease it is best to clean up all foci of infection before doing thyroidectomy, but this sometimes requires extracting all the teeth, one or two at a time, and may take several months.

As a rule the thyroid should be removed first and diseased tonsils later, when these two conditions are present. A tonsillectomy may change a mild thyroid disease into a severe one so that the patient cannot stand an operation on the thyroid. The same is true of major operations such as cholecystectomy, following which a fatal hyperthyroid reaction may occur.

Cholecystitis is very commonly associated with thyroid disease of the toxic modular type in patients past forty years of age. In this connection I have observed an interesting phenomenon, namely, that after an attack of cholecystitis, pyelitis or acute supperative condition with fever, when the patient's inflammation subsides, the hyperthyroid symptoms also improve. Several times this has enabled me to operate a patient safely who seemed, before the intercurrent infection, to be inoperable.

I have attempted to reproduce this effect in very severe thyroid disease by causing a febrile reaction with typhoid vaccine injections. In several patients the results were encouraging, although I have not treated enough cases in this way from which to draw conclusions. I am convinced that there is an immunity phase in thyroid disease which is similar to the immunity of infection.

The loss of weight usually attending toxic goiter makes it a serious complication in pulmonary tuberculosis. I have operated for goiter six times in the presence of pulmonary tuberculosis. The results have been very satisfactory. It is interesting to note that of the many patients seen with great loss of weight from thyroid disease, I have noted none who has contracted tuberculosis as a terminal complication.

Next to infections the complications arising from the heart and blood vessels are outstanding in their importance. Thyroid disorders do not cause disease of the heart in the strict meaning. The toxic effect of a diseased thyroid gland often produces an arrythmia. This condition coupled with fatigue of the muscle may eventually lead to a complete cardiovascular failure. This rarely gets so bad, however, that function may not be restored after removal of the thyroid. I recall one such case in which there was œdema up to the breasts. There was ascites and the lower edge of the liver was four inches below the costal margin. This patient survived thyroidectomy, after careful preparation, and examination today reveals no hint of her former desperate condition.

When thyroid disease has been present for years hypertension is always present. This is one of

the insidious results of the so-called simple harmless goiter which has had no treatment or may have been treated off and on with medicine and x-ray. Under the use of iodine and rest the blood pressure will improve sufficiently to warrant operation and thyroidectomy will bring about a permanent betterment, although not a restoration to normal. One patient, forty years of age, entered the hospital with a blood pressure of 220/60. Ten days later it was 140/74. Three months after thyroidectomy her pressure was 150/80. When *essential* hypertension is present and a recent thyroid disease is acquired the demand for operation soon becomes urgent as a patient with a blood pressure of 250 or 300 cannot long endure the effects of a toxic goiter. These patients stand operation very well if they are not entering a state of circulatory failure as shown by too great a spread between the systolic and diastolic pressure. One case who underwent thyroidectomy with the blood pressure 256/150 while on the table recovered and lived three years, dying of apoplexy. Removal of the goiter, however, does not cure a hypertension present before the goiter appeared.

I have operated a few times where toxic goiter with its tachycardia has been added to a rheumatic heart disease. This is probably the worst complication with which we have to deal. Thyroidectomy is indispensable and the patient is least able to stand an operation. In such a case graduated procedures are useful; ligature of all four vessels, one at a time under local anesthesia, followed by lobectomies.

It has been my good fortune to do thyroidectomy eight times for thyroid disease in pregnancy without interrupting the pregnancy in a single case. The risk is so slight that thyroidectomy should always be done where indicated rather than to let the patient go to term with the burden of a toxic goiter. In this connection it is fair to mention that a patient, not known to be pregnant, aborted six days after thyroidectomy. There is a normal elevation of the basal metabolic rate of 20 points in pregnancy. If there is enlargement of the thyroid, not sufficient to require operation, iodine will be helpful to a pregnant patient. If the basal metabolic rate is low in pregnancy, particularly in patients who have had thyroidectomy, give one-half grain of thyroid daily. Thyroid medication may be helpful in sterility and tendency to miscarriage. In pregnancy where thyroid disease has been present for a long time calcium is needed as well as iodine. In long-continued thyroid disease there is an increased calcium output but the blood calcium remains normal, the calcium being taken from the bones so that there results an osteoporosis which can be shown to exist by x-ray. Thus the storehouse for calcium is depleted.

Some patients with thyroid disease have little disturbance of mental processes. The majority, however, exhibit an emotional instability of greater or less degree. In nine instances this has been so severe as to constitute a true insanity. Six of these patients were entirely restored to a normal state of mind by thyroidectomy so that they were healed mentally and physically. The other three became worse immediately after the operation, but recovered slowly over several months time.

On one occasion an operation was performed for toxic goiter and cancer of the breast at one sitting. The loss of weight from thyroid disease seemed to favor the growth of a complicating cancerous process. The patient recovered and lived six years, finally dying of cancer metastatic in the femur. Multiple operations are not to be encouraged with thyroidectomy.

Diabetes is frequently complicated with thyroid disease. Because of the fact that the hyperthyroid case has difficulty in storing sugar, thyroidectomy, when needed, increases the glucose tolerance and helps the diabetic. In my experience the diabetic stands thyroidectomy when he is properly prepared, just as he stands other operations well, such as cholecystectomy.

Severe metabolic disturbance is a serious complication from an operative standpoint. It is inadvisable to operate if the patient has a rising metabolic rate or if the patient is losing weight. Some patients will continue to lose weight for some time after the basal metabolic rate has fallen to a point that would indicate safety for operation. A few pounds in weight gained is one of the best signs we have indicating that an operation may be done with safety. It is dangerous to operate if a great deal of weight has been lost in a relatively short time. For instance, some years ago, I lost a patient whose weight had gone from 186 to 125 in three months, although she was in very good condition otherwise. Were I treating such a case now I would insist that the patient be caused to regain at least ten or fifteen pounds, over a period of three months, before operation.

The oculist is frequently the first to be consulted by a goiter patient. Exophthalmos often causes much distress to eye workers. In many cases it will not subside after all other symptoms are gone and in a few cases will progress after thyroidectomy and in the presence of a low minus basal metabolic rate.

In the milder forms of thyroid disease the necessity for working may be the important factor in deciding to operate. If the patient could live a life of leisure she might defer or escape operation. The patient's social and economic situation plays a very important part in thyroid surgery.

The youngest patient I have operated for goiter was five days old, the oldest seventy-five years of age. In a five day old infant I had the uncanny experience of doing a thyroidectomy without any anesthetic. Though awake and conscious, the baby paid no attention to the operation. Old people stand thyroid surgery well. The need for surgical relief is more urgent in the aged as they cannot endure thyroid disease well and do not recover from its harmful effects in the same measure as the young.

DISCUSSION

J. R. YUNG, M. D. (Terre Haute): In his classification of goiter Dr. Link has adopted the one recommended by the American Association for the Study of Goiter. This is purely a clinical, and not a pathological, classification. He dealt clearly with a large number of important phases, the understanding of which are necessary for the performance of successful surgery in this field.

In only a few years the operative mortality, including the gravest cases, has decreased from about 15 per cent to 1 or 0.5 per cent. With this lowering in the operative mortality patients and doctors have more confidence in, and patients more willingness to submit to, surgical intervention. The mortality rate is highest in the cases of nodular goiter. The figures given by Clute for his 1931 series were only 0.63 per cent for exophthalmic goiter, while in the nodular group the mortality rate was 3.03 per cent. This proportion in the mortality rate between exophthalmic and nodular goiter is approximately the experience of other observers, as well as in our own series of over 850 operations for goiter. Because of this higher mortality occurring in the nodular goiter I wish to discuss a little more fully this particular type.

This mortality is due to the fact that most of these nodular goiter cases become toxic, especially in the later decades of life. The onset is insidious, the tremor, the weakness and tachycardia, especially when this occurs in women, frequently is attributed to the menopause. These symptoms may be present for a number of years before it is recognized that a nodular goiter is responsible for the condition. The recognition often is so late that a very serious cardio-vascular disease has developed. Also in the later decades of life, this condition is complicated by co-existing degenerative diseases due to other etiological factors. In this state they present a very grave surgical risk. This type is also responsible for most of our cases of tracheal pressure and almost wholly the cause of intrathoracic goiter. Here the technical removal is more difficult with greater hazard of asphyxia from tracheal collapse, hemorrhage from friability of the tissues, and inaccessibility of blood supply, injury to the recurrent nerves and parathyroids, because of their displacement from their usual anatomical location. We commonly leave a portion of the thyroid tissue around the compressed trachea to prevent tracheal collapse where we suspect, or by X-ray can see, that there is some atrophy of the cartilagenous rings.

The nodular goiter is the basis for 90 per cent of all thyroid malignancies as stated by Clute in a review of the work at the Lahey Clinic. In Lahey's report of a study of 1484 nodular goiters he found malignancy in 6 per cent. It is needless to say that in these malignancies there is added difficulty in technic, and that they are prone to metastases and recurrence.

As the nodular goiter is not influenced materially by medical treatment, usually develops toxicity, and is responsible for tracheal pressure, I advocate surgical removal early, when the body has attained its full development, say between the ages of 25 and 30, or earlier if the goiter shows evidences of toxicity.

To me the term "border-line group" is misleading and a misnomer because in this particular group of cases some are goiter and the others not goiter. The term borderline is again misleading in that it gives us the feeling that an underlying neurosis is a forerunner, or may be the cause of developing goiter. This has never been proved and I think it is not accepted by those familiar with goiter work. This group should be called "the doubtful group." If this is done we will persist in our efforts to make a positive diagnosis.

Dr. Link brought out the fact that we must make our diagnoses clinically by history, general examination, and palpation of the thyroid gland. We must appreciate its density, size, irregularities, and that a small nodule may be productive of toxic symptoms in which event it should be removed. Many are inclined to diagnose the doubtful group by means of their basal metabolic rate, which is purely a laboratory method open to errors in technic and in interpretation, leading undoubtedly to the removal of healthy thyroids with, naturally, no amelioration of the symptoms except for a few weeks following operation, due to the enforced rest in bed and the temporary psychic effect.

In regard to malignancy in goiter, the text book description of malignancy is of cases so far advanced that little can be gained by surgical interference. These late cases usually have metastases and even though radium or Roentgenotherapy may be employed only temporary benefit can be expected. A history, very suspicious of malignancy, is a recent rapid growth of an old quiescent nodular goiter, pain radiating toward the mastoids, hoarseness and blood-stained sputum. The distinctive physical finding as Dr. Link has stated is the firmness and I would add lessened mobility of the gland. The hardness due to calcification is differentiated from malignancy by the shadow shown on X-ray.

As to results, in the cases we had under observation, those cases which were discovered so early as not to be recognized except by the pathologist, and immediately received Roentgenotherapy, have had no recurrence after five years. Several cases diagnosed on the table, but not recognized clinically, have had no recurrences over a period of three years. Those cases which were recognized clinically and were operated died within two years.

Much has been said about the choking sensation and pressure in the neck. Very few of those patients have a toxic goiter, or any goiter at all. They commonly are cases of neurosis. The history shows that they have been nervous all their life, usually state they had no trouble with the neck, no symptoms until their attention was called to it by some member of the family, or school physician.

MARTIN E. KLINGLER, M. D. (Garrett): I would like to have Dr. Link tell us how to recognize malignancies of the thyroid before we operate, and what should be our guide in operating on these cases.

ROBERT M. MOORE, M. D. (Indianapolis): It is my belief that the recognition of the heart in thyroid disease demands almost as much emphasis as the proper treatment. I am sure there are in this State, and many others, a number of bedridden patients with heart failure who are unable to carry on because the underlying cause, namely, hyperthyroidism, is unrecognized. They are treated as heart cases, but in overlooking the diseased thyroid we fail to give these patients the relief to which they are entitled. It is a well recognized fact, and many articles have been published on this subject, that thyroid disease, especially of the latent type, very frequently masquerades as heart disease.

What is the so-called thyroid heart? It is any heart upon which the drive of hyperthyroidism is acting. There may be other etiological factors contributing to the heart changes, such as rheumatic heart, sclerotic heart, hypertensive heart, etc., but it is the drive of hyperthyroidism upon the heart which brings on heart failure earlier in many cases than it would be apt to occur. Our success in giving relief to this class of sufferers is to be on the lookout for hyperthyroidsm, as it many times plays the most important role in heart failure in this group of patients. Dr. Yung stated that these patients often become toxic late in life, referring primarily to the adenomatous goiter type. It is my belief that they are always toxic, even though they do not show symptoms of toxicity, and later in life, because of the long-continued action of the diseased thyroid, go into heart failure. One should always suspect the possibility of hyperthyroidism in a patient with a tachycardia of 90 or above, in the absence of fever. Again, one should always be suspicious of hyperthyroidism in paroxysmal auricular fibrillation, especially if there is no evidence of mitral stenosis. It has been shown that these patients with paroxysmal fibrillation may have a normal metabolism at the time they are in regular rhythm, but when taken during the attack of fibrillation may show definite increase in their metabolic rate. It is well also to keep in mind that in many patients with auricular fibrillation, permanent type, who do not respond to digitalis therapy, the thyroid should be considered as a possible factor in their trouble. Lugol's solution often has acted as a definite aid as a therapeutic diagnosis in this group of patients.

Andrus and McEachern have stated that it is perhaps the most accurate and certainly the most optimistic attitude to look upon the heart in hyperthyroidism as suffering from its own accelerated metabolism, and from the load thrown upon it by the metabolism of the body as a whole. From both these burdens it can happily be relieved by relief of the hyperthyroidism.

GOETHE LINK, M. D. (closing): As to the question Dr. Klingler asked about the recognition of malignancy, in my experience malignancy has been rather easy to recognize, although I never have seen it early enough to cure the patient. The first point in recognition is the fixation of the mass, and the second is invasion. In most of the cases that I have seen the larynx was invaded early, producing a hoarseness that helped to make diagnosis possible. Blood may appear in the sputum early.

As to the question of operating upon young individuals, we must be governed by the conditions in each individual case. The five-day old baby mentioned in my paper was operated upon because he could not swallow, and there was also marked interference with respiration; I have seen a typical exophthalmic goiter in a five-year old girl, and she needed operation as much as any older individual. In patients fifteen or sixteen years of age we prefer to wait, if not toxic, until they are older.

There are two points I wish to emphasize about two widely divergent types of thyroid disease. Many cases of this disease show no disturbance of the metabolic rate, and the thyroid enlargement is inconspicuous. Diagnosis in these cases can best be made by palpation. If you can palpate the posterior borders of the gland, it is my belief that the thyroid is diseased and you have a definite basis for diagnosis.

The other type is the nodular goiter occurring in old women. The formation of nodules represents a defense reaction. Most of these patients have had hyperthyroidism for many years, and during these years they have been toxic, often insidiously and moderately; then all at once they go into physical bankruptcy.

The deduction I wish to make from this is that we must eliminate the term "simple goiter." There is no such thing as harmless, simple goiter. When there is disease in the thyroid gland that can be seen and felt, it requires treatment, preferably surgical.

METHOD FOR PREDICTION OF SEX IN THE UNBORN

By injecting rabbits fully 3 months old, whose testes were in the inguinal canal, with urine from women in between five and ten months of pregnancy, JOHN H. DORN and EDWARD I. SUGARMAN, San Francisco (*Journal A. M. A.*, Nov. 12, 1932), were able to prognosticate the sex of the unborn child in eighty of eighty-five cases. The basis for their prognosis was the microscopic changes in the testis of the rabbit, noted forty-eight hours after injection. The testes of the rabbits injected with urine from women carrying an unborn female child were developed precociously. The testes of the rabbits injected with urine from women carrying an unborn male child were not so stimulated.

Correction: In the editorial "Appendicitis" (December issue), page 555, fourth paragraph, fifth line, should read "pressure necrosis" instead of "pressure neuroses".

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JANUARY, 1933

EDITORIALS

"IN THE BEGINNING"

In assuming our new duties as Editor of THE JOURNAL we are in nowise unmindful of the task that lies before us; in fact, we have a most intimate conception of what will be expected of us; we are cognizant of the successes that attended the efforts of our predecessor, the late, lamented Bulson. It was our pleasure and very great privilege to enjoy a most intimate relationship with him, and it is to this former alliance that we shall look for much help and guidance.

We are most fortunate in having the assistance of an Editorial Board and a Managing Editor; nor do we overlook the fact that we will have the very timely and capable assistance of Miss Toman, who was with Dr. Bulson for many years. We have every confidence in our staff; we know that they will respond to every call, and these calls will be numerous; hence, we take up our new relations with few misgivings.

Again, we have had various relations with the numerous activities of our association over a period of more than a quarter century; we have served in various offices and committees; in this service we have established contacts which we believe will prove of material assistance in our new position. We feel we are rather well acquainted with the affairs of our association and know somewhat of the problems confronting us.

As to the policy of THE JOURNAL we have few changes to offer at the present time; mechanically it will come to you in about the same dress; it will continue to reflect the opinion of the Indiana profession as we view it. We will make the utmost endeavor, in both our editorial and scientific departments, to keep pace with medical progress within our state, for this is a State Journal. There will be no one-man opinions coming from the editorial department; the board is in entire accord as to policy, and editorial comment is to be in harmony with that policy.

We shall endeavor at all times to maintain a close relationship with our parent organization, the American Medical Association; we shall become devout students of those in authority in that great organization and, while we may never become a West or a Fishbein, we shall have the satisfaction of having attempted to follow in the footsteps of some good leaders.

However, we shall reserve the right—which seems to be an editorial heritage—to disagree, on occasion, with such eminent authorities as hold forth at 535 North Dearborn Street, Chicago. These disagreements, we assure you, will amount to little more than an occasional discussion in THE JOURNAL.

This publication is owned by the members of the Indiana State Medical Association; its control is in your hands; as your Editor it is but for us to do your bidding and it is your help, your advice and your kindly criticism that we want above all else. A long time ago we were in what we deemed to be a tight place; we did not know the way out; we were asked what we most desired and something prompted us to answer—"LIGHT!" It happened to be the proper answer. What we most desire now is editorial light and we trust it will come as promptly as on the former occasion.

We cannot be expected to write all the editorials, though the board will supply many of these; we cannot be expected to dig up editorial notes in an unlimited fashion and it is to the membership at large that we shall have to look for many of our inspirations. If you have a personal inspiration for an editorial and want to write it yourself do so and send it along; it will be submitted to the board —the Editor takes no chances on single judgment in such matters. Or, if you have the idea and want it executed, send that along and one of our staff will put it in words. Matters of association policies, always subject to much conversation, may be freely and frankly discussed with your editorial staff; we welcome such things—they help make a good journal.

In our advertising columns we will admit only "accepted" articles, and it goes without saying that mention of the non-accepted variety in scientific articles will be taboo. We shall most earnestly, not to say valiantly, oppose anything that smacks of state medicine; we shall attack any form of commercialism in medicine and we will uphold the ethics and traditions of the profession as we have observed them in more than thirty years in its service.

THE JOURNAL has reached the age of twenty-five years; it has achieved a high standing in American medical literature; that standing must be maintained; it will be maintained if we can but have the support your Editorial Board deems its just due.

BLOOD GROUPS

It is most unforunate that there has been so much irregularity in the naming of the various

blood groups. Originally Landsteiner proposed three groups and numbered them, 1, 2, and 3. Later a fourth group was added. Still later Moss in this country and Jansky in Europe further elaborated the understanding of the subject and gave numbers to the various groups. Unfortunately their groupings do not coincide and as a result a great deal of confusion has resulted. Confusion is always bad but in this case it is positively dangerous. Jansky seems to have published his grouping first and it is universally used in Europe. Until recent years Moss's terminology has been favored in the United States in spite of the fact that Jansky has priority and has been officially accepted by clinical pathologists. At the present the confusion is particularly bad for the reason that the eastern cities and some western cities use Jansky while the others use Moss. Groups 2 and 3 are the same in both but groups 1 and 4 are interchanged. Inasmuch as there are some surgeons who use the "universal donor" frequently it is rather obvious that it is extremely important that they not confuse groups 1 and 4 because the "universal donor" is group 4 according to Moss and group 1 according to Jansky. Another objection to these methods of nomenclature lies in the fact that from a genetic standpoint they make the understanding of the heredity of these groups very difficult indeed.

Because of these several objections a more systematic method of designating the groups has been sought. It will appear to some that the new method merely makes another set of symbols to be remembered but with a little study the new method has many advantages. By the terminology of Hirshfeld the agglutinogens of the blood cells are designated by the letters A and B. Those cells which have neither of these are given the symbol "O" while those that have both are "AB." The relation of the various groups is indicated as follows:

Hirshfeld (Letter)	Jansky (Roman Numeral)	Moss (Arabic Numeral) (Universal Donor)
O	I	4
A	II	2
B	III	3
AB	IV	1

The big advantage of the method of Hirshfield lies in the fact that it is so easy to see when trouble may be expected if we simply remember that neither A or B may safely be added as new elements in the donor's blood. For example, if the patient is a member of group O then the donor must be group O. If the patient is A, then the donor can be either O or A though it is always somewhat better to use the donor of the same group when that is possible. If the patient is B, then the donor can be O or B (B preferred). If the patient is AB and the donor can be O, A, B, or AB (AB preferred). In other words we seek merely to add no new agglutinogens when we give blood. Group O is the "universal donor" for the good reason that the cells have no agglutinogens whatever and so cannot add any. It is obvious that there is little reason for confusion when this system is used.

A further advantage lies in the ease with which the genetic formulae can be handled. Illustrations will make this clear. Ten combinations of parents are possible.

I. If both parents are of Group O, all of the children will be of group O because the children can inherit only such agglutinogens which the parents possess. Hence, if the parents have none, the children will have none.

2. If both parents are group A the children may be either O or A.

3. If both parents are B the children will be O or B.

4. If both parents are AB the children may be O, A, B, or AB.

5. If one parent is O and the other A the children will be O or A.

6. If one parent is O and the other B the children may be O or B.

7. If one parent is O and the other AB the children will be O, A, B, or AB.

8. If one parent is A and the other B the children may be O, A, or B.

9. If one parent is A and the other AB the children may be O, A, B, or AB.

10. If one parent is B and the other AB the children will be O, A, B, or AB.

These ten formulae include all the combinations that can be made.

By reference to these formulae it is sometimes possible to prove that a child of questionable parentage is *not* the child of a given pair. It is not possible by this method to prove that a given child *is* the child of a given pair. A little study will convince one of the superiority of this method of designating the blood groups. It is a method based upon the fundamental facts rather than an arbitrary method that is capable of much confusion.

THERE IS ALSO A MINORITY REPORT

With a fanfare of publicity and a semi-official governmental blessing through no less of a personage than a cabinet officer, the recommendations of the Committee on the Costs of Medical Care have been ushered forth upon a depression-tossed America, after a five year study. Backed as was the project by generous foundation funds, supported by wealthy laymen, carried to completion largely by lay investigators, directed by a man of confessed leanings toward governmental control of medical practice, it is little wonder that the majority report of the committee advocates a system of group payment and group medical service which amounts to socialization of medicine. It is little wonder, also, that as a result of this report, medicine finds itself up against a battle which, if lost, will mean the breakdown of all those traditions, ethics, ideals and rugged individ-

ualism that the profession has held dear, and which the public has come to respect and to admire.

So skillfully handled has been the publicity following the release of the report, and so clever and effective has been the bally-hoo by press, printer, and follow-up propagandist, that if the public is not "sold" on socialized medicine before this thing is through, it is simply because the medical profession is so active, so intelligent and so right, that its position cannot be assailed. In fact, so clever has been the follow-up campaign of the committee's majority report that the public and many members of the medical profession think that the majority report is the only official statement of the committee. Of course, that is not the case, and every physician, and for that matter every citizen in Indiana, should be familiar with the first of the three minority reports, which reflects the views of organized medicine, as well as the majority report, in order to have a real picture of the situation.

So much has been written about the study, especially of the majority report, that it is almost impossible for each physician to be familiar with all the latest comments. However, one at least should be familiar with the summary of the majority and the principal minority reports that appeared in the December third issue of the Journal of the American Medical Association, and the editorial in that issue regarding them. Especially should the younger physician, the interne, and the medical student, be familiar with this, as it is the doctor of the future who will have to adjust himself to any changing conditions that may arise. Report or no report, the man who is established today probably will carry on along very much the same lines as he is now working.

The majority report is based upon a meagre five-year study; the minority report is based upon a background of perhaps 1,500 years of medical tradition. The only place that the minority report has failed has been in publicity.

A review of some of the high points gathered from the 201 pages of the published report may be worth while. The report is extremely well done from a research standpoint, and might well be a standard upon which research could be made into the inadequacies of our present banking system, the tortuous methods of our legal profession, a study into our staggering industrial system and our political and governmental system of expensive bureaus and commissions as well. The medical profession is not the only one that should be put on the spot. Medical organizations would be blind if they condemned the entire majority report because of its recommendations for officially recognized and protected group practice and group payment for medical services. Many interesting and worthwhile facts are brought out in the majority report. In no unmistakable terms the majority report points out facts that should be shouted from the housetops—the small income of the average doctor; the essential function of the general practitioner; the necessity of retaining the time-honored relationship between patient and physician; the tremendous amount of money wasted yearly by the American public upon patent medicines, cultists and charlatans.

The medical profession and the average citizen owe an everlasting debt of gratitude to the officers of the American Medical Association for the very existence of a minority report. Had it not been for the foresight of Olin West and others, the majority report advocating the installation in America of group payment and group medical practice, which has proved unsuccessful in Europe, would have gone unchallenged. It is understood that shortly after the committee met, some five years ago, some of the physicians who were in active practice sensed a socialistic tendency in the committee and obtained an understanding that if any differences in opinion should arise, opportunity should be given for a minority report to be published simultaneously with the majority report. This foresight on the part of the leaders of organized medicine in this battle to maintain the individualism of medical men, may be said to correspond to the stand made by General Pershing not to brigade American forces under the French and English officers during the World War. As it now stands, if for no other reason than to bring forth such a masterly defense of medical ideals and medical ethics as is contained in the minority report, the million dollars or so spent by the committee on making the survey is worth while.

Whereas, the majority report takes 150 pages to deal in facts and figures and bring forth a theory, the minority report takes 32 pages to deal in theories and codes of ethics, and brings forth facts. The majority story is that medical care can best be given the public by the socialization of medicine; the minority story is that the individual patient suffers from such socialization. The majority says group practice and group payment is the solution; the minority says that such experiments of group practice and group payment have failed to produce better medical care in England, France and Germany, where they have been tried.

THE 1933 LEGISLATURE

It is with a great deal of interest that we will observe the doings of the coming session of the General Assembly of Indiana. We have been doing this particular bit of observing for some quarter century, but the 1933 session affords a special interest for many reasons. In the first place this will be the first time in many years that one political party has had such an enormous majority in both branches; so much so that there will be little excuse as to political interference with party legislation. Our Democratic friends are riding high, wide and handsome; in the offing we see no reason why they should not have their own sweet way with affairs in general.

In so far as our profession is concerned we are

advised that our legislative committee has no legislation to offer; that is to say, they deem it advisable not to offer any at this time. From a practical standpoint we would like to submit certain pieces of legislation, but are more than willing to "yield our time" to affairs of graver importance. We should very much like to have a new medical practice act, this to succeed that of 1897 vintage.

We do need such an act because the ancient one has been so perforated with amendments, adverse court decisions, etc., as to make it a bit more than old and passé.

We are advised that our very competent State Board of Medical Registration and Examination has had under consideration for quite some time the advisability of presenting a new medical law at this session; such a law has been at least partially drafted. In view of present conditions they have deferred to matters of more general import, in which stand we most heartily concur.

While it is not the province of a profession to enter into a discussion of state matters, yet we feel an expression of opinion regarding current legislation may not be amiss. We believe we express the opinion of the medical profession of Indiana when we say we opine that the greatest task of the present assembly is that of an equable solution of the tax problem. While we do not overlook the fact that our House of Delegates at the Michigan City session last September unanimously concurred in a resolution to the effect that we objected very strenuously to the prohibiting by-law of the use of *any* remedy, and while there are other matters in which we as a profession are vitally interested, yet we are more than willing to yield first place to the most important matter of a tax system that will be fair to all concerned.

Regardless of politics—and politics should not enter such a situation as now confronts us—we must have some form of relief that will solve the greatest of our present problems. The 1933 legislature has a golden opportunity—if they will but get down to business at once, clean up the legislative slate, and—adjourn in not more than forty days. Plenty of time to do a lot of work, plenty of work to do.

THE MULTIPLE ETIOLOGY OF DISEASE

After bacteria as a cause of disease were discovered it was commonly inferred or assumed that a given disease had a given specific cause. The typhoid bacillus caused typhoid fever, the tubercle bacillus caused tuberculosis, and that was all there was to it. It is beginning to appear that the matter is by no means so simple. It is true that one cannot have tuberculosis unless one has the corresponding germ but there are a lot of other predisposing causes which seem to be quite or nearly as important as the germ itself. Recently the tendency has been to broaden our views concerning etiology. We no longer look for a single germ as the cause of pyorrhea for example, but believe that the condition is one in which any of several organisms may produce the symptoms as they act in the comparatively devitalized tissues of unhealthy gums. At the bottom the disease may then be due to a metabolic disturbance, bad nourishment, lack of care or other abuses of the tissues which allow the various organisms of the mouth to gain a foothold and further injure the tissues. Somewhat the same situation is likely at the bottom of colitis and other chronic inflammations.

Several diseases have recently been shown to be due to an organism that has gone before and has "plowed the soil" for the secondary invaders which have come after and have been largely responsible for the symptoms and complications of the disease. It is believed that influenza and the common cold are due to filtrable viruses—not the same one for both conditions. Until the recent epidemic it was believed that psittacosis was due to the organism described by Nocard in 1892 and called by him bacillus psittacosis, but it appears that the real cause is a filtrable virus. Lately an article has come out claiming that the bacillus pertussis is not the real cause of whooping cough but is merely a secondary invader following an infection with another filtrable virus. This latter work is not as yet proved by any means but it is suggestive. Years ago hog cholera was supposed to be due to bacillus suipestifer but it was later proved that a virus was at fault. Now we are coming back to the idea that probably *both* are necessary to cause the infection. It seems that many or most of the symptoms are really due in all probability to bacillus suipestifer but that this organism can hardly produce its effect except in those animals which are infected by the virus and thereby rendered subject to the suipestifer infection. Vincent's angina is believed to have two organisms as the cause—the fusiform bacillus and the spirillum of Vincent. Swine erysipelas cannot be produced under artificial conditions with any degree of accuracy and it is believed that there is an unknown etiological agent which must act with the organism that is commonly given as the cause. It is well known that the staphylococcus infection of a wound makes that wound much more suitable for the breeding of tetanus germs. Some authorities say that tuberculosis does not become very destructive until secondary infection sets in. While we would not wish to subscribe to this view entirely, it certainly is a fact that secondarily infected tuberculous lesions are much more destructive. Many other illustrations of the principle of multiple etiology might be given but it is hardly necessary to illustrate the principle that we no sooner get these problems apparently solved than they are shuffled again by some ambitious scientist who will not accept them as being solved. Beyond reasonable doubt bacteriology is making vast strides in the past few years and it is not impossible that many diseases will be much better understood before long.

HIGH-PRESSURE SALESMEN

Do not be misled by the enthusiastic or harassed hospital superintendent grabbing at schemes, nor by high-pressure salesmen working on commission purveying group hospital insurance. The plan is not utopian. It is unproved. It has many possible back lashes. It may form a Frankenstein to the hospital, and it is definitely one more step towards state medicine.

The American Medical Association warns the profession not to be stampeded into the socialization of medicine, but to remain calm, stand steadfast, and maintain control of the practice of medicine in all of its branches.

This advice is not to be interpreted to mean inactivity. There are comparatively too few physicians giving these problems serious thought. They are allowing the officers of the associations, local, state and national, to assume the burden and responsibility which is primarily theirs. Each and every individual physician should familiarize himself with the various hospital schemes and the report of the Committee on the Costs of Medical Care. He should study them, analyze them, be able to discuss them intelligently and impart to his patients the disadvantages and dangers hidden in such schemes not apparent to the laymen.

We do not want revolution, but evolution! Thereby will we be able in the future, as in the past, to adopt the best methods and practices which lead to the greatest good for the greatest number, and maintain and surpass the scientific medicine achieved during the past century.

Withhold your approval, either individually or jointly, of any of these schemes until your Committee on Health Insurance has made further investigation and brought in its recommendations.

EDITORIAL NOTES

DEAR DOCTOR:

THE JOURNAL and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital.

We invite and urge you to use this Service.

It is absolutely *free* to you.

The Cooperative Bureau is equipped with catalogues and price lists of manufacturers, and can supply you information by return mail.

Perhaps you want a certain kind of instrument which is not advertised in THE JOURNAL, and do not know where to secure it; or do not know where to obtain some automobile supplies you need. This Service Bureau will give you the information.

Whenever possible, the goods will be advertised in our pages; but if they are not, we urge you to ask THE JOURNAL about them, or write direct to the Cooperative Medical Advertising Bureau, 535 N. Dearborn St., Chicago, Illinois.

We want THE JOURNAL to serve *you*.

A HAPPY and Prosperous New Year to all our folks! At least we may hope 1933 will deal more kindly with us than its immediate predecessors.

THE reports of the Committee on the Costs of Medical Care, and the developments from these reports, will be reviewed from month to month in the columns of THE JOURNAL.

PUBLICATION date of THE JOURNAL, beginning with this issue, is the first of the month rather than the fifteenth. The Council suggested this change, believing it will prove popular with our members.

AS SCHOPENHAUER said, adequate hells are easy to imagine, but no heaven good enough to even spend a long life in, let alone eternity, has ever been described. No sane person would want to live in any of the utopias.

READ the program for the Annual Secretaries' Conference. If you can stay at home after you look that over, you won't care what you miss in the future. Every subject is of vital interest to the physician; every speaker is an authority on his subject.

WE will watch with a personal interest the doings of our good friend, Dr. George D. Miller, senator from Cass County; we have an even bet that, ere the session is concluded, George will "pull" a roll call, Long Meter style. George sure does like his roll calls—long form.

ANNUAL SECRETARIES' CONFERENCE
3:00 P. M., Sunday, January 22, 1933
INDIANAPOLIS ATHLETIC CLUB

SUBJECTS:
HIGH PRESSURE SALESMANSHIP AND GROUP HOSPITALIZATION
THE PHYSICIAN AND HEALTH INSURANCE
VETERANS' HOSPITALIZATION
THE LEGISLATURE
REPORTS OF COMMITTEE ON COSTS OF MEDICAL CARE

SPEAKERS:
A. M. MITCHELL, M. D., Terre Haute
J. H. WEINSTEIN, M. D., Terre Haute
J. B. ROBB, M. D., Detroit
F. S. CROCKETT, M. D., Lafayette
E. H. CARY, M. D., Dallas, Texas.

(See complete program on page 32)

SINGLENESS of purpose is almost a *sine qua non* to success in life. Owen Meredith puts it well when he says,

"He who seeks one thing in life, and but one,
Will likely attain it before life is done;
But he who seeks all things wherever he goes
Is likely to reap from the hopes which he sows
A harvest of barren regrets."

RECENTLY the Sunday newspapers carried a front page story regarding a Georgia physician who burned some $81,000 in patients' bills—as a "Message of Hope." The local publicity given this item may result in much benefit to the physician, as many of his delinquent patients may now come back to him and carry on, on a cash basis. We believe the plan is not without merit.

THE JOURNAL of the Indiana State Medical Association accepts only advertisements from reputable business concerns. If it were not for the money derived from these business houses, it would cost the state organizations considerably more to operate the state journal. Every member of the Indiana State Medical Association should support the advertisers in this journal—YOUR JOURNAL.

A RECENT bulletin of the Vanderburgh County Medical Society asks members of that society to patronize the advertisers in this JOURNAL. We hope that not only the members of the Vanderburgh County Medical Society, but the members of all of the counties in the State of Indiana will give their patronage to advertisers in THE JOURNAL. These advertisers help to support your JOURNAL—they deserve your support.

DUES for 1933 are payable on or before January 31st; delinquency begins as of February 1st. This year, more than ever, it is important that said dues be paid on time; many of our members are depending on State Association medical defense. Defense is available only when a member is in good standing at the time service is rendered and when the suit is brought. A little attention to this detail may save you many sleepless nights.

WE are more than pleased with the appointment of the Committee on Public Policy and Legislation, Drs. George R. Daniels of Marion, Frank H. Jett of Terre Haute, L. J. Danieleski of Gary, L. E. Fritsch of Evansville, and J. William Wright of Indianapolis. This is one of the most important committees the president has to name and we congratulate Dr. Weinstein on his selections; we know the capabilities of all five men and will rest assured that the legislative affairs of the Association are in good hands.

BLOOD will tell! We knew that sooner or later our executive-secretary would ooze into politics. Sure enough he did, and is now a member of the House! Well, Tom has a lot of ability, is a square shooter, can mix with 'em all, and should come through without a scratch on him. (None of which is original; as a lad, down in Wild Cat, Indiana, we heard a native Hoosier express a like opinion about a man who was about to leave for the legislature.)

THIS issue of THE JOURNAL includes the list of councilor districts—not only the councilors, but the officers of each councilor district and the date and place of the 1933 district meetings. The information is not complete in this issue. Please check the information given for your district and let us know if anything can be added or if any mistake has been made. We want THE JOURNAL to be of value to you. Interest yourself enough to help us keep every bit of published information correct and up to date.

IN these days of reduced income from our advertising pages it is more important than ever that we do two things: patronize those who patronize us; let them know that we saw their ad in THE JOURNAL. Without advertising we should have to go back to the old plan of publishing an annual volume of "Transactions," or very materially increase our state dues. Neither of these plans is quite feasible, so let's adopt the surer plan, that of telling our friends that we appreciate their patronage.

WE recently heard one of our younger practitioners commenting on the fact that he had successfully treated a number of cases of a rather recently described disease; that his "patent treatment" was rapidly curative and that it never failed. The recent literature on the subject fails to record any such panacea and if this young man has discovered a "cure" he should report it before his county society. It doesn't pay to be a sponge; squeeze yourself, once in awhile, and see if something good comes out!

THE Editorial Board has instituted a new department with this issue of THE JOURNAL—that of "The Voice of the Doctor." Our lay press provides a channel for the expression of thought of their readers, so why not have a space for medical readers in a medical journal? This is a sort of free lance proposition, though of course the matters presented will be properly edited. 'Most anything, save personalities, may be discussed in this column, so send along your squibs; we will look 'em over and print those not designed to hurt a fellow practitioner's feelings.

MALPRACTICE suits are too commonly caused by caustic comments of fellow physicians. We feel we are often too prone to criticise our brethren, said criticisms being taken too literally by our auditors. Our legal friends advise us that it is comparatively easy to arrange for "expert" medical testimony in support of malpractise cases—this for a specified compensation—whereas but a few years ago this was practically impossible. We believe our county societies could do much toward eliminating many of these suits were they to appoint a committee to discuss the case with all parties concerned.

THE JOURNAL desires to keep in touch with all committee chairmen; we would like to know what you are doing; what progress you are making; what, if anything, we can do to further your work; and we would very much like rather frequent re-

ports for THE JOURNAL. Our observation is that most of the criticism that has been directed toward various administrations has arisen from the fact that the general membership is not properly advised as to what is going on. Let's hear more from our committee chairmen; if nothing more, an occasional letter via The Voice of the Doctor.

DR. F. WEBB GRIFFITH, of Asheville, North Carolina, closes a very practical paper entitled "A Few Fallacies in Gynecology" very pertinently as follows: "Undoubtedly we are just on the threshold of discoveries in endocrinology, but at present I fear our therapy is based more on the unsupported statements of pharmaceutical houses than on scientific facts or on proven clinical observations. I trust that what I have said will not be construed as being pessimistic or destructive in character; but progress is best made by discarding the so-called remedies which have been proven fallacious."

IF you have not already read the abstract of the final report of the Committee on the Costs of Medical Care (Journal A. M. A., Dec. 3, page 1954), it will be well worth your while to do so; also the leading editorial in the same issue. Our editorial page also carries comment on same. The majority report of this committee—which we maintain was improperly termed, makes recommendations that, if generally adopted and carried out, mean a lot of grief to our profession. While we do not wholly agree with the minority report, we endorse it. The whole subject matter is one with which we should all be familiar and every physician should read the complete report.

PHYSICIANS are invariably among the first to be solicited when any form of charity drive is opened. We are expected to come across, generously, on any and all occasions, notwithstanding the fact that no other profession or group contributes so generously of its time and talents. In these days of welfare drives, community chests and what-nots, we are expected to, and should, do what we can. A small percent of our members find themselves utterly unable to help in a financial way, but the average doctor can manage a small cash contribution. Considerable—and probably just—criticism has been leveled at some physicians who seem able to afford new cars and yet cannot afford to contribute to such funds.

THE long distance phone stock salesmen are still at it—we had thought they would go into retirement until such time as medical men had had opportunity to accumulate a little cash reserve. The latest report is from a southern Indiana member who was advised that an investment of a little money, right this very minute, would enable him to sit pretty for some time to come. If these chaps have such remarkable investments, why not sell them to their neighbors rather than spend good money in phoning to folks with whom they are not acquainted. We used to hear the advice—"consult your banker"; most of us do not have a banker to consult, so about the best bet is to use your head, which process will usually result in saving your money.

ONE thing that the minority report makes clear is that the final solution of this problem of supplying medical care at a cost that each individual citizen can afford is up to each local county medical society. It is the duty of each county medical society in Indiana to act now. "We believe that the county society approved by and under the supervision of the state and national societies is the proper unit of organization to attempt such experiments," states the minority report. Therefore, each county society should study the recommendations of the minority report now, and send a delegation of their members to Indianapolis to attend the annual secretaries' conference on Sunday, January 22nd, where this and other problems of medical economics are to be discussed by speakers of national reputation.

AT present it is more important than ever that dues be paid promptly. Aside from everything else, the value of medical defense is worth much more than the cost of the entire membership. The cost of one malpractice suit would pay dues for several years. You pay much less than you do to your lodge. You spend much more for many foolish or unnecessary things. It was never more important than now that we stand together in solid phalanx when outside forces are working against us to disrupt and control us. It is not pleasant for the local secretary to dun the members. Give him a happy New Year and yourself peace of mind by paying now. Your officers and committees serve without pay. All they ask is your earnest support and cooperation, and thereby your dues will be returned tenfold in value.

IN these parlous times, when the gas bill seems high and the rent all out of proportion, it is not strange that we should hear mutterings, hither and yon, to the effect that our annual dues are all out of proportion. Fact is, our dues are not high enough, as is. We know of no other state society, comparable in size and undertakings, with annual dues so low as ours. As it is, our Budget Committee is hard put to it to make a balance without cutting off some present activity; and Lord knows! we surely do not want to retrench, these days of all others. At the recent mid-winter meeting, Ferd Weyerbacher, our most efficient treasurer, darned

near became ecstatic when he announced that, from present appearances, we would emerge from the red, this year. Boy, was Ferd happy! No, brethren, this is not the time to lower our state dues.

WE recently attended the Annual Conference of State Secretaries and Editors and were agreeably surprised at the attendance from over the country and the marked interest displayed in the program. This was a Medical Economics meeting, the entire list of papers having to do with the most pertinent of the questions confronting the profession today. That the profession is being aroused to the many perils that seem imminent was evidenced by the character of the papers and the discussions. The undercurrent—lobby and luncheon chatter—would seem to indicate that many believe we are many years late in taking up these subjects, as is so cleverly pointed out by our versatile friend, Dr. Austin, this issue (see The Voice of the Doctor). As a whole, the profession seems to have been slow to mark, not the trend of the times, but rather the effect on medicine of the trend of the times.

THE Bureau of Publicity, always issuing worthwhile bulletins to the press, is to be particularly congratulated on the release for December 17th, "Campaign Against Appendicitis." That the death-rate from this disease is too high cannot be denied; that much of this can be avoided does not admit of argument; it is but a matter of education of the public. If we can impress the point that a continued abdominal pain is a serious matter, that purgatives should not be used in such cases, and that a physician should be consulted, we will have accomplished our purpose and the death-rate will materially lessen. We wonder if it might not be well, in publishing the mortality rate in appendicitis, to divide the cases into two classes, those before and after perforation; many of these tables are seen by the laity and they will be quick to perceive the need of avoiding delay in such cases.

IT will be interesting to note what our current legislature has to say about Medical Poor Relief—just what plan will be adopted to carry on that work; certain it is that the medical profession is mightily concerned with the problem. One of our larger county societies wrestled with this big problem for almost two years; they devoted ten or more entire meetings to its local solution; they spent no little time and money in investigation. They at one time proffered practically free medical and surgical services to the indigent in a population of more than 200,000, and this proposal was turned down by the commissioners. Instead, two contracts were awarded, at $2,500 each, per month, to two physicians, they to render medical and surgical services to the indigent in the two communities. (This did not include hospital charges.) Now arises the natural question in the minds of the non-elect, "Why should we do *any* charity work, when others are being so well paid?" Odd, isn't it?

ONE would think the collection agency racket would be in the utter doldrums, in these days of so much unemployment. Seems as not, as "Scattergood Bains" is wont to say. They appear more numerous than ever. Of course there are many reliable agencies, but the fact remains that a great lot of them are plain gyppers. One of our associates, who has a considerable amount invested in the latter variety, says he can tell the good from the bad the minute an agent begins to make his sales talk; he proved his theory, recently. A brisk, sleek and glib specimen walked in to his office and began his introductory remarks; he got no further than the introductory stage, however, when friend Tom opened up on him with a line we never knew he possessed. The poor salesman beat as hasty a retreat as possible and was seen to take the first bus Chicago-ward. Our Thomas remarked that had this chap been representing a reliable concern he would not have stood for such a tirade. We do not guarantee the reliability of this method, but it did seem to work in this instance.

MARCH 4th brings a new Congress; in fact, it just about brings a new Washington; it remains to be seen what "the new deal" means for us. We all are agreed that governmental expenses must be grossly reduced—this in hundreds of millions, annually. Department after department is under severe indictment in the matter of reducable expenditures, but the ones concerning us most are those having to do with the pyramiding of medical, surgical and hospital costs to the government. We are all more or less familiar with the management of non-service-connected disabilities and are agreed that this has come to be an unnecessary evil; it is being constantly taken advantage of by thousands who are well able to pay for such services, for one thing. At the recent secretaries-editors conference, during one of the recesses, we heard a man state that one phase of the subject had not been much discussed—that of free medical and surgical service to members of Congress at Walter Reed Hospital. It is an admitted fact that it is common practise for these folks to go to this hospital for any and all sorts of treatment and it remains to be established that such services have been paid for. It was recently publicly announced, and as yet denials have not been recorded, that some members of Congress and their families, through the practise of nepotism, have an annual governmental income of as much as twenty thousand dollars. Yet they and their families have free access to Walter Reed Hospital. Why? Our comment is that we should have begun to complain at about the time the hospital was opened.

THE PRESIDENT'S PAGE

FAREWELL

FRANKLIN S. CROCKETT, M. D.,
PRESIDENT FOR 1932.

The changing status of medical practice is most evident when the present is brought into sharp relation to the past. The individual private practice still remains, but imposed upon it, or "chiselling in" on it, are certain socializing developments. The state has created boards of health to deal with community health problems. Volunteer health agencies have insinuated their educational programs. Philanthropists have financed health centers and foundations, giving free service. The federal government has built an extensive hospital system to render without charge medical and surgical attention to some 4,500,000 ex-service men, suffering from disabilities not connected in any way to their army service. Insurance companies and others are selling medical and hospital service in certain places. Industrial insurance is educating men away from their family physician loyalty and finally the Committee to Study the Costs of Medical Care would socialize the whole system of medical practice, if one may judge by their recent report.

As an individual, the physician is helpless to protect himself against these encroachments to his way of living. Medical organization affords him his only protection and it is his collective voice only, expressed through his county society, his state association, and his American Medical Association, that can make itself heard in the councils of those who are legislating for him.

Clear thinking men are in charge of medical associations who see distinctly this threat to medicine's best interests. It is questionable if many of the rank and file of the profession are acutely aware of the many influences that threaten us. The great need is an awakening. Some plan should be devised to impress every physician that his cooperation is needed in educating his people exactly what bureaucratic medicine, state or socialized medicine, will mean.

Dr. Joseph Weinstein, in assuming the presidency of our state association for 1933, will accomplish much. He has the vision, the energy and the devotion to render us all a great service. If we in the profession give him the aggressive and intelligent support he has a right to expect, we will look upon 1933 as one of greatest usefulness and accomplishment for the science and practice of medicine. May I ask for him that loyalty and enthusiasm from our membership which has made 1932 such a pleasant memory for me?

GREETINGS

JOSEPH H. WEINSTEIN, M. D.
PRESIDENT FOR 1933.

With humbleness and pride I greet our members; with humbleness in the hope that I may be able to fill the responsible position with which you have honored me, and with pride in the earnest fellowship of our association members.

The year 1933 brings in new problems and continues some old ones for us to solve. The veteran hospitalization problem seems well on its way to solution, and under the able hands of our past president, Dr. Crockett, with the assistance of the committee, I have confidence of a satisfactory conclusion.

Annual registration is again under consideration. For our protection and prosecution of irregulars, we should be willing to pay a small annual fee. The state has never furnished sufficient funds for this purpose, and examination and registration fees paid by licentiates does not furnish sufficient money for proper prosecution.

The report at this time of the Committee on the Costs of Medical Care will cause much concern among many of us. Coming at this time of depression, it will make many converts among underprivileged people. The socialists and sociologists, the philanthropists and the public health officials will make all possible capital of it at this time. Our State Committee is making an intensive study of the report as well as conditions in the state. A special committee is studying the indigent problem. These two committees will make important reports.

Let us not be stampeded. Let us remain open minded, but let us not forget that medicine in America has reached its high standard by the individual pioneering physician, independent of lay or political influences, and unhampered by compulsion.

This is the year the legislature meets, and, though we have no bills to present, there will be much work to do to prevent reactionary legislation. The Legislative Committee is already working, and each and every one of our members should hold himself in readiness to respond to requests and calls for aid when the committee calls.

Our JOURNAL is under new editorial management this year. Our whole-hearted loyalty to the new editor and his board is a duty, and cooperation will prove a pleasure and a profit. This is our JOURNAL. It will be just as good as we make it.

In closing this New Year message, may I express the hope that the old aphorism, "darkest before dawn" is a truism, and the dawn of 1933 be one of prosperity, happiness and achievement.

SECRETARIES' PAGE

ANNUAL SECRETARIES' CONFERENCE

3:00 P. M., Sunday, January 22, 1933

INDIANAPOLIS ATHLETIC CLUB

PROGRAM

3:00 p. m.	Registration.
3:15	Call to order and opening remarks, by A. M. Mitchell, M. D., Terre Haute, chairman.
3:30	"High Pressure Salesmanship and Group Hospitalization," by J. H. Weinstein, M. D., Terre Haute, president of the Indiana State Medical Association.
4:00 to 4:45	"What Should Be the Attitude of the Physician Toward Health Insurance Plans," by J. M. Robb, M. D., Detroit, Michigan.
4:45 to 5:00	Discussion.
5:00 to 5:15	"Veterans' Hospitalization," by F. S. Crockett, M. D., Lafayette.
5:15 to 5:30	Discussion.
5:30 to 5:45	"What's Doing in the Legislature," by Thomas A. Hendricks, Indianapolis.
5:45 to 6:00	Discussion.
6:00 to 6:30	Recess and get-together.
6:30	Dinner.
	"Majority and Minority Reports of the Committee on the Costs of Medical Care," by Edward H. Cary, M. D., Dallas, Texas, president, American Medical Association.

SECRETARIES' GET-TOGETHER JANUARY 22

A. M. MITCHELL
CHAIRMAN

The physicians of Indiana are now working under trying times. There is less work and less pay. The economic situation today has caused a lot of people who have swivel chair jobs to pick on the medical profession to furnish relief for the people because they have lost their jobs and their salaries have been lowered. In other words, they want to put the medical profession on a salary basis.

The physicians of Indiana know that these swivel chair persons have only given their side of the story. It is now up to the medical profession as a whole to place their side of the story before the individual doctor and then before the various communities in the state.

Every organization regardless of how sound it is or how well it can take care of its own business is dependent on public opinion. Modesty is a virtue but it must not be permitted to shadow the truth to the detriment of the medical profession.

Now the medical profession has facing them in bold face type these subjects which are of vital importance to every practitioner of medicine.

First. Is the question of health insurance (voluntary and compulsory).

Second. Contract hospitalization.

Third. Group practice of medicine as formulated by the Committee on the Costs of Medical Care.

Fourth. Lay organizations practising medicine as is done by the garment workers and others in New York. Also it is done by various endowed foundations.

Fifth. Problems that can come up in the coming legislature which meets in January, 1933.

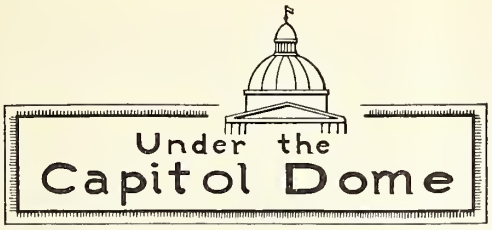
Sixth. Medical organizations that are talking Contract Medicine, such as American College of Surgeons.

With all these problems facing the medical profession the Committee on Secretaries' Conference had a meeting in Indianapolis on December 7, 1932, to discuss these questions. We decided that the sooner these problems were put to the county secretaries the better off would be the medical profession.

We decided to call the Secretaries Conference for 1933 on January 22, the meeting to begin at 3 p. m. and extend through dinner, which is free. We are hoping to get up a good program with one or two speakers of national reputation to help us discuss these questions and to help steer us on the right track.

This committee believes it is the duty of every county secretary to come to this meeting so that he can carry back to his society the problems before us and the ideas gained as how to solve them for the best interests of the medical profession.

Come! Come! Come! If you do not you may have a job as an artisan and not a job as an individual.



Much goes on daily under the Capitol Dome which directly or indirectly affects the life of every citizen of the State of Indiana. This is covered very thoroughly by the press in "stories" from the Governor's office, office of the Secretary of State, office of the State Board of Health, and the score or more boards, commissions, departments and bureaus through which our state government functions. However, much goes on under the Capitol Dome (and in the State House Annex that has come into being within recent years) that is of particular importance to the medical profession and the individual physicians of the state. The newspapers, published as they are for the public, cannot devote time and space to report in detail many of these regulations, rules, opinions, or actions, which are of great concern to the medical profession. In order to keep the profession informed, and in touch with the work of the state officials and their branches of government, as this work affects the physician, the Board of Editors of THE JOURNAL today creates this column as a regular feature.

* * *

Starting January fifth, and for the next sixty days, the 1933 session of the legislature will be the most important and prominent happening under the Capitol Dome. The medical profession is particularly fortunate this year in having four of its members in the General Assembly—two in the Senate and two in the House of Representatives. The "senator doctors" are Isaac N. Trent, of Muncie, who will represent Delaware County, and George D. Miller, of Logansport, who will represent Cass and Fulton counties. This is Dr. Miller's first experience in the legislature and is Dr. Trent's first experience in the Senate to which he has graduated after spending many years as a member of the House. Dr. George E. Denny, of Madison, Indiana, is returning this year for his second term of office as a representative from Jefferson and Scott counties, while Dr. William F. Schenk, of New Corydon, Indiana, will come to Indianapolis for the first time as a legislator. The dental profession has two representatives, both in the lower House—Dr. Millard E. Dill, of Plainfield, and Dr. Robert L. Stanton, of East Chicago. Bern B. Grubb, of West Lafayette, a pharmacist, comes with fine recommendations from the members of the Tippecanoe and Warren county professions. In addition to these men, Alanson L. Albright, of Cayuga, who will serve in the Senate, and Amos F. Nelson, of Thorntown, are listed as veterinarians. T. A. Hendricks, executive secretary of the Indiana State Medical Association, who will serve in the lower House, is one of the eleven representatives from Marion County.

* * *

For several months the cultists have been flooding the legislators with all sorts of propaganda. The main burden of this cult appeal, most of which comes from the Indiana Chiropractic Association, is that the Indiana State Board of Medical Registration and Examination is unfair to drugless healers. One of the statements is as follows: "No drugless practitioner has been admitted to take examination since his school was placed under the medical board by the 1927 amendment to the medical practice act." Just how false this statement is may be seen from the fact that in 1927 six osteopaths were licensed; in 1928, five; in 1929, four; in 1930, six; in 1931, nine; and in 1932, nine. Incidentally, the highest mark received from the Board in 1932 went to an osteopathic student. If, as is claimed by the chiropractor's association, the state board is so unfair and prejudiced, how could it happen that an osteopathic student would receive from this same board the highest grade out of 130 who took the examination?

"THE VOICE OF THE DOCTOR"

Anderson, Ind., November 21.

Dear Doctor Weinstein:

I have your kind letter of the 18th informing me of my appointment as chairman of the Committee on Health Insurance, for the coming year, as part of the activities of the Indiana State Medical Association. I regret that my enthusiasm for the problems of State Medicine which has extended over the past twenty-five years, has found so little response that the present conditions resemble nothing so much as a panic on the deck of a sinking ship.

The establishment of a Department of Medical Economics by the American Medical Association is a fine gesture, but ten years too late to stop the leaks. When I was asked to discuss the insurance problem before the 1931 meeting of the Indiana County Secretaries at Indianapolis and some literature from the deliberations, resolutions and considerations of the Michigan State Society was sent to

me, it merely showed they had wakened up to facts that I had written up in an article and published in the American Journal of Clinical Medicine eighteen years before.

Our delay, indifference and drunken optimism has permitted matters to reach such a state, that these problems have passed from our hands into the hands of the politicians and various lay social organizations with various utopian programs that mean the ultimate socialization of the profession.

Those who have been reading the various articles in the Medical Economics section of the Journal of the American Medical Association realize the widespread development of State Medicine and various local attempts to compete with it, in the formation of so-called clinics offering complete medical, surgical and hospital care on a monthly premium basis. Besides these we have the medico-political grafters taking advantage of the taxpayers in the care of the unemployed and indigent. We have the lodge and club doctors. We have industrial physicians and surgeons. We have state and county institutions for the care of the insane, feeble-minded, epileptic, criminal and tubercular patients, and in some states special cancer institutions. We have government venereal clinics and government hospitals caring for more syphilitics than died of war injuries. Government hospitals care for any ex-service man or woman who is ill of anything, and plans are being fostered to extend this free service to all the dependents of not only the ex-service men and women but to offer the same benefits to all civil service employees and pay them compensation of at least $2.65 a day for all the time of their disability.

And what are you going to do about it? VERY LITTLE. For two reasons. One, that we are only one-tenth of one per cent of the people as a whole. Second, that conditions at the present time show that not over twenty per cent of the people can afford to pay for adequate medical or surgical care, because we have made our work too expensive for the average family to pay for. Too many specialists are doing routine work that the average practitioner should do. Too many unnecessary X-ray and laboratory examinations are done. Too many economic conditions we are trying to remedy with medicine and surgery. Too many endocrine dysfunction patients are resulting from our orgy of sex literature and sex appeal movies. Too many male and female prostitutes are avoiding the responsibilities of a home and children through the formalities of divorce. Too many incompetents are trying to run our government, our finances, and our morals. Too much big business using high pressure salesmanship to create discontent and break down sales resistance. Too many politicians thinking of their next election and too few statesmen thinking of the next generation. Too many Loewensteins, Kreugers, Insulls and Capones. Too many Aimee Semples, Mary Baker Eddies, and similar cultists, that failed to meet up with their Brigham Young at the proper time and place. Too much religion and too little Christianity. Too much so-called scientific medical training and too little training in the humanities. Too much Freud and too little Spinoza.

As someone has otherwise said we are born in a hospital, bred in a hotel, raised in an apartment, married in church, work in a factory, die in an automobile, buried from a mortuary and go to hell to rest.

Fishbein says that ninety-five per cent of the subscribers to the Journal of the American Medical Association read the obituaries first, then the tonics and sedative section, and then throw the Journal into a pile of previous unread journals, that are sold to the junk man later. Nothing I have ever written before has changed any one's viewpoint enough to get them to thinking along lines that would have anticipated the collapse of the profession in this country. Nothing that our late lamented Dr. Bulson so frequently wrote about in his editorials on State Medicine was ever taken seriously. As the Krankenkassen have dictated the terms of medical income in Germany and Austria and the similar plans in England and France has reduced the professional man to a job hunter, so we are ripe for our turn to be broken on the wheel. We have had a chronic economic appendicitis from prosperity and high living, but have been too busy to stop and have the cause of our trouble removed. We took one too many drinks out of the prosperity bottle and followed it with a big physic and our economic appendix has BUSTED. We may live through it, but we are going to have a long belly-ache.

I hope the other members of the committee are optimists and can write the things you wish written so they will be read by the men who need to read them. As chairman of the committee it is my duty to see that the other fellows do the work, and I am willing to let them do it, and have all the honors.

Most sincerely,

M. A. AUSTIN.

DIPHTHERIA DEATHS FOR NOVEMBER, 1932

Thirty deaths for the month of November is the largest number of deaths in any one month for the past three years and brings the total for the first eleven months of the year to 140 which is three more than the total number for each of the last two years. Thirty deaths for November means one funeral a day from a disease that is strictly and definitely preventable. One school room full of children wiped out. Thirty funerals at $300.00 each would cost $9,000.00. 347 cases were reported during the month of November which figured at $50.00 each would be $17,000; considering cost to the family, doctor bills, anti-toxin, loss of school, inconvenience of quarantine, would make a total of $26,000.00 which certainly would immunize lots of children. One of the principal differences between immunizing the children and letting them die is that it costs about the same, but by the former plan you keep the children.

Deaths by counties are given below. It is obvious that certain counties are going to be a very black spot on the map for 1932.

County	Total for 1932	November, 1932	County	Total for 1932	November, 1932
Allen	7	1	Martin	1	0
Boone	1	1	Monroe	5	0
Brown	2	0	Montgomery	1	1
Clark	3	1	Morgan	1	0
Clay	1	0	Noble	2	0
Clinton	2	0	Orange	1	0
Crawford	1	0	Parke	1	0
Daviess	3	0	Perry	3	2
Delaware	14	3	Pike	3	0
Dubois	1	0	Pulaski	1	0
Fayette	2	1	Putnam	2	0
Fountain	1	0	Randolph	2	0
Franklin	1	0	Shelby	3	0
Gibson	1	0	Spencer	2	1
Grant	2	1	Tippecanoe	4	3
Greene	5	1	Vanderburgh	5	0
Hamilton	3	0	Vermillion	1	0
Henry	1	0	Vigo	6	2
Howard	4	2	Wabash	2	2
Huntington	1	1	Warrick	2	0
Jackson	4	1	Washington	1	1
Knox	3	1	Wayne	3	0
Lake	10	1	Wells	1	0
Lawrence	6	2	White	1	0
Madison	1	0	Whitley	2	0
Marion	4	1			
				140	30

DEATH NOTES

M. C. LEETH, M. D., practicing physician in Indianapolis for forty years, died November 24th, aged 65 years. Dr. Leeth was a graduate of the University of Tennessee, College of Medicine, Memphis, in 1895.

CARLOS D. LANE, M. D., of Ligonier, died November 15th, aged 49 years. Dr. Lane was one of the most prominent physicians and surgeons in Noble County, and for many years had held the position of coroner of Noble County. He graduated from the Medical College of Indiana, Indianapolis, in 1905, and was a member of the Noble County Medical Society, the Indiana State Medical Association, and the American Medical Association.

WILLIAM J. SANDY, M. D., of Martinsville, aged fifty-eight years, died December 11th. Dr. Sandy graduated from the Medical College of Indiana, Indianapolis, in 1900. He was a member of the Morgan County Medical Society, and the Indiana State Medical Association.

ULYSSES GRANT WHITING, M. D., of Martinsville, died December 13th, after an illness of several months. Dr. Whiting was sixty-three years of age. He graduated from the University of Louisville School of Medicine in 1897, and following years of practice in Wadesville and New Harmony, he studied in Chicago, New York and Vienna, returning to practice at Mt. Vernon. In 1924 Dr. Whiting established the Whiting Mineral Springs Sanitarium at Martinsville. He was a member of the Morgan County Medical Society, the Indiana State Medical Association and a Fellow of the American Medical Association.

M. F. WEDDING, M. D., of Rome, Indiana, died December 5th, aged 76 years. Dr. Wedding graduated from the University of Louisville, School of Medicine, in 1885.

SAMUEL A. SMITH, M. D., of Carbon, died December 10th, aged sixty-three years. Dr. Smith had practiced in Carbon only a year. He graduated from the Illinois Medical College, Chicago, in 1904.

ALFRED HENRY, M. D., of Indianapolis, aged fifty-eight years, died suddenly, December 12th. Death was due to a heart attack. Dr. Henry was a former president of the Indiana Tuberculosis Association, one of the organizers and first president of the Marion County Tuberculosis Association, and former president of the Mississippi Valley Conference on Tuberculosis. Dr. Henry was president of the Marion County Tuberculosis Hospital at Sunnyside, where he had served continuously since its organization in 1917. He was an associate professor of medicine in the Indiana University School of Medicine and was a member of the Marion County Medical Society, the Indiana State Medical Association, and a Fellow of the American Medical Association. He was widely known for his skill in diagnosing and treating tuberculosis.

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HOOSIER NOTES

MEMBERS of the Adams County Medical Society met at Decatur, December 9th. Dr. T. J. McKean, of Montpelier, presented a paper on "Banti's Disease." Officers were elected for 1933.

THE Hamilton County Medical Society held its regular monthly meeting at Noblesville, December 13th. This was the annual homecoming banquet. Officers were elected as follows: President, Dr. J. E. Hanna, Noblesville; vice-president, Dr. Russell Havens, Cicero; secretary-treasurer, Dr. H. C. Kraft, Noblesville. Dr. O. B. Pettijohn, of Noblesville, was installed as lifetime honorary president.

DR. J. H. P. GAUSS, of Indianapolis, presented a paper on "Some Pitfalls in Diagnosis" before members of the Cass County Medical Society at Logansport, December 16th. Annual election of officers resulted as follows: Dr. Foss Schenck, Logansport, president; Dr. B. W. Egan, Logansport, vice-president; Dr. E. L. Hedde, Logansport, secretary and treasurer. Dr. C. L. Viney, of Logansport, was named censor, and Dr. George Miller, of Logansport, delegate.

THE Porter County Medical Society met at Valparaiso, November 29th, with Dr. N. K. Forster, of Hammond, as the principal speaker. Dr. Forster's subject was "Differential Diagnosis of Pelvic and Urinary Diseases in the Female."

MEMBERS of the Madison County Medical Society met at the Grand Hotel, Anderson, November 21st. Dr. Henry R. Alburger, of Indianapolis, presented a paper on "Nephritis." Attendance numbered thirty. Members discussed the local diphtheria situation. Children who showed positive Schick reactions were presented, the Schick test was administered to others, and the administration of toxoid was demonstrated.

PATIENTS in the Healthwin Hospital at South Bend listened to the funeral service for Dr. St. Clair Darden, superintendent of the hospital. Ear phones were provided for each one and the services were broadcast from the church.

DR. FRANK RODENBECK and Dr. Earle Stockney were hosts to the Hamilton County Medical Society at Arcadia, November 15th.

MRS. JAMES F. PERCY, of Los Angeles, California, has taken the place of the late Mrs. Walter Jackson Freeman as president of the Woman's Auxiliary to the American Medical Association.

THE American Association for the Study of Goiter for the fourth time offers three hundred dollars as a first award and two honorable mentions for the best three essays based upon original research work on any phase of goiter presented at their annual meeting in Memphis, Tennessee, May 15, 16, and 17, 1933. It is hoped in this way to stimulate valuable research work, especially in regard to the basic cause of goiter. Competing manuscripts must be in English, and must be submitted to the corresponding secretary, Dr. J. R. Yung, 670 Cherry Street, Terre Haute, Indiana, not later than April 1, 1933.

DR. G. J. GEISLER, of South Bend, was made president of the South Bend Kiwanis Club at the annual election of officers, December 1st.

THE Indiana Society for Mental Hygiene held a meeting at the Claypool Hotel, Indianapolis, December 12th. Dr. Max A. Bahr, superintendent of the Central State Hospital, conducted a clinic at the hospital in the afternoon. Speakers at the morning session included Dr. C. O. Holmes, of Gary; Dr. W. A. Hacker and Prof. R. C. White, of Indianapolis; Dr. W. C. Van Nuys, of Newcastle, and others. "Mental Hygiene in the Field of Education" was discussed at the evening meeting when the speakers were Dr. Mervin A. Durea, of Ohio State University; Grover Van Duyn, of Indianapolis; and Robert B. Hougham, of Franklin.

THE Fountain-Warren County Medical Society met in Attica, December 1st. A chicken dinner was served, following which a business meeting was conducted. Dr. R. L. Bailey, of Lafayette, was the principal speaker.

DR. MERLE HOPPENRATH, of Elwood, has been made a member of the Board of Control of the Ella Kehrer Madison County Tuberculosis Hospital to succeed the late Dr. C. A. Walton.

THE Dearborn-Ohio County Medical Society held its annual banquet and election, December 1st, at the Dillsboro Sanitarium.

THE Pan-Pacific Surgical Association has postponed its 1933 meeting for one year or longer, dependent upon improvement in economic conditions. Dr. Forrest J. Pinkerton, of Honolulu, is secretary of the association.

GEORGE L. CLARK, Ph. D., of the University of Illinois, has received the Grasseli medal for 1932 in recognition of his research on Roentgen rays.

DR. E. L. CARTWRIGHT, of Fort Wayne, has moved his office from 1106 Taylor Street to 306 Medical Arts Building.

AT the December 1st meeting of the Marion County Tuberculosis Association, Dr. William A. Evans, of Chicago, was the principal speaker. Dr. Evans warned the people of Indiana of the consequences of failure adequately to support public and private health endeavors in this period of economic distress.

DR. CHARLES SOUDER, of Indianapolis, spoke on "Diseases of the Respiratory Tract" before the Carroll County Medical Society at Delphi, December 9th.

"HAND INFECTIONS" was the subject of a paper by H. C. Ruddick, M. D., of Evansville, before the December 12th meeting of the Gibson County Medical Society at Princeton. Attendance numbered seventeen. The Baylor Hospital group insurance plan was discussed and the society denounced this or any other known plan of a similar nature.

MEMBERS of the Hancock County Medical Society met at the Bowman Hotel, Greenfield, November 18th. Dr. Charles Titus, of Wilkinson, discussed "Diseased Tonsils and Their Systemic Effects." Dr. S. W. Hervey, of Fortville, was the principal speaker before the December 8th meeting of this society.

DR. E. P. MITCHELL has moved from New Albany, Indiana, to Defiance, Ohio, where he has opened an office for the practice of eye, ear, nose and throat.

DR. L. NEFF ASHWORTH, of Connersville, has been in New York City since October 1st, where he has been doing some post-graduate work in surgery at the New York Polyclinic Medical School and Hospital. He expects to return home about the first of the year.

FIVE years of research has located 887 persons in the United States and 57 in Canada, who are both deaf and blind. The present study is the first ever made of the deaf-blind and their problems. Some efforts to register, educate and care for the deaf-blind are now being made in London, Paris, Berlin and Montreal.

DR. J. T. BIGGERSTAFF, of Wabash, oldest practicing physician in Wabash County, was elected president of his county society at the December meeting. Dr. Biggerstaff also was made an honorary member of the organization for the remainder of his life. Other officers elected were Dr. L. B. Rhamy, vice-president, and Dr. Robert LaSalle, Secretary.

TO ALL COUNTY SOCIETIES:

As of January first, 1933, our JOURNAL will be issued under the direction of a new editor and editorial board; Executive Secretary Hendricks will become managing editor. Our success, to whatever degree we may attain, will depend on many things other than those connected with the official family of THE JOURNAL.

We want to make THE JOURNAL newsy as well as scientific; we want to report the goings-on of all sections of our state, and it is to the county societies that we must look for most of this information.

In addition to the papers presented at the annual sessions we want snappy, well-written papers on timely subjects from our members. Papers of unusual merit, read before your society, will be gone over by the Board, and as many of these as possible will be used. If there is anything you wish discussed editorially we shall be glad to look into it for you. News notes and personals are of interest to the average reader and we welcome these. We also are glad to have reports of your meetings.

We would like to be put on your mailing list, that we may receive notices of all your meetings; we want to know what is going on in medical Indiana.

Comments and criticisms will not be considered out of place, though we would prefer the latter to be of the constructive variety.

In the main, THE JOURNAL will appear in its old form and dress, though we have a few innovations, as was to be expected. Among these is a new department, "The Voice of the Doctor." Under this heading we shall be pleased to publish such correspondence as may be of general interest; the only matter barred from this department will be letters having a personal slant—that is to say, we will not open our columns to personal disputes.

All matters pertaining to the editorial phase of THE JOURNAL are to be addressed to the Editor; all other matters to the Indianapolis office.

In conclusion let us again say that we want your cooperation; this is your JOURNAL; we are but your servants, trying to present to you each month, as best we can, a readable, helpful piece of literature.

E. M. SHANKLIN, M.D.

THE Noble County Medical Society met at Albion in the Albion Hotel, December 2d. Dues were collected; officers were elected; and members of the society discussed the treatment of the poor and revision of the county fee bill. Three new members were admitted to the society, making the membership in Noble County 100 per cent.

THE Wabash County Medical Society met at Wabash, December 7th, for election of officers.

THE Dearborn-Ohio County Medical Society met at the Dillsboro Sanitarium, Dillsboro, December 1st. Fifteen members and their families enjoyed a program of music and reading. Officers for 1933 were elected as follows: C. F. Fletcher, Sunman, president; J. F. Treon, Aurora, vice-president; and E. L. Libbert, Lawrenceburg, secretary-treasurer.

THE November 22d meeting of the Grant County Medical Society was held at the Spencer Hotel in Marion. Dr. H. Allison Miller presented a paper on "Thyro-Adrenal Function." Attendance numbered twenty-five.

MEMBERS of the Marshall County Medical Society met at the Marshall County Hospital, December 7th. Dr. Donald Reed presented a paper on "Some Uses of Sodium Amytal Other Than Surgical." Attendance numbered thirteen.

THE Terre Haute Academy of Medicine will hold its annual meeting at the Hotel Deming on Friday evening, December 2nd. Honorable H. J. Anslinger, U. S. Commissioner of Narcotics, of Washington, D. C., was the guest speaker.

DR. R. A. CRAIG, of Kokomo, presented a paper on "Nervous Disorders in Childhood" before the Howard County Medical Society, November 4th. The meeting was held at the Howard County Hospital.

MEMBERS of the Hendricks County Medical Society were hosts to their wives for dinner at the House by the Side of the Road in Danville, November 18th. Dr. John Warvel, of Indianapolis, talked on "Diabetes."

THE United States Civil Service Commission has announced open competitive examinations for the position of junior medical officer (interne) to fill vacancies in Saint Elizabeth's Hospital, Washington, D. C. Two types of interneship are offered: (a) accredited interneship of two years (A. M. A. classification 1) and (b) a post-graduate interneship in psychiatry of one year (A. M. A. classification 2). Competitors will be rated on their education, training and experience. Information and application blanks may be obtained from the secretary of the U. S. Civil Service Board of Examiners at the post office or custom house in any city, or from the commission at Washington, D. C. Applications must be on file with the manager of the fourth U. S. Civil Service District, Washington, D. C., not later than January 10, 1933.

HANDBOOKS for speakers, "Cancer Compend," Inc., recently announced the appointment of Dr. Hans Molitor, of the University of Vienna, to the research staff of the company. Dr. Molitor will assume the direction of research work in pharmacology.

A HANDBOOK for speakers, "Cancer Compend," and "Cancer and Its Care" (a handbook for nurses) are the most recent publications of the American Society for the Control of Cancer. The "Compend" gives information regarding the prevalence of cancer, its diagnosis, treatment and prevention; public health aspects; control agencies; and additional facts which may be helpful in preparing an address on the subject for the laity as well as points to be considered by the speaker. The second book outlines the special nursing procedures to be employed in the event of hemorrhage or secondary infection, in tracheotomy, cystotomy and in the care of terminal cases. Copies of these handbooks may be obtained from the American Society for the Control of Cancer, 25 West Forty-third Street, New York City.

SOCIETIES AND INSTITUTIONS

INDIANA STATE MEDICAL ASSOCIATION

The Council

The regular midwinter meeting of the Council of the Indiana State Medical Association was called to order by Dr. O. O. Alexander, of Terre Haute, chairman, at 10:15 a. m., Thursday, December 1, 1932, at the Indianapolis Athletic Club, Indianapolis. Roll call showed the following present:

Members of the Council:

1st District—John H. Hare, Evansville.
2nd District—H. C. Wadsworth, Washington.
3rd District—H. C. Ragsdale, Bedford.
4th District—H. P. Graessle, Seymour.
5th District—O. O. Alexander, Terre Haute.
6th District—Samuel Kennedy, Shelbyville.
7th District—L. A. Ensminger, Indianapolis.
8th District—M. A. Austin, Anderson.
9th District—F. T. Romberger, Lafayette.
10th District—E. M. Shanklin, Hammond.
11th District—E. O. Harrold, Marion.
12th District—E. M. VanBuskirk, Fort Wayne.
13th District—J. B. Rogers, Michigan City, retiring councilor.
W. B. Christophel, Mishawaka, councilor-elect.

Officers:

F. S. Crockett, president 1932.
J. H. Weinstein, president 1933
E. E. Padgett, president-elect.
A. F. Weyerbacher, treasurer.
Albert Stump, attorney for the association.
Thomas A. Hendricks, executive secretary.

Members of the Executive Committee:

William H. Kennedy, chairman.
H. H. Wheeler.

Editorial Board:

Ernest Rupel, Indianapolis.
Pierce MacKenzie, Evansville.

Upon the motion of Dr. Shanklin, seconded by Dr. Romberger, the reading of the minutes of the Council meetings held in Michigan City in September was dispensed with. (These minutes appeared in the October number of THE JOURNAL.)

Dr. Alexander mentioned the fact that the Editorial Board had had its first meeting the previous evening at the headquarters office, and the members of the board were introduced to the Council.

The time and place of each district meeting and the names of the district officers are to be printed in THE JOURNAL each month.

Dr. W. B. Christophel, who succeeds Dr. J. B. Rogers, councilor of the Thirteenth District, was introduced at this time.

Reports of Councilors by Districts

Short informal reports of the councilors showed that medical organization throughout the state is in excellent shape. Some of the high points of the reports follow:

Second District—Wadsworth—Having an efficient permanent secretary of the district society such as Dr. J. S. Brown of Carlisle has been a great help. Monroe County has given up the idea of leaving the Second District and joining the Third.

Third District—Ragsdale—As we have the next state meeting at French Lick, it is the intention of our district to put this over with the help of the Orange County society. We will visit each society in our district and have each society appoint a committee to help the Orange County society.

Sixth District—Kennedy—We have gotten along with the loss of one member in the last year, which I think is very good.

Tenth District—Shanklin—We lost twenty members this year, seventeen of them from Lake County. Group hospitalization has not cropped out yet in our district.

In 1932 we had at least seven meetings in Lake County entirely devoted to an attempt to arrive at a plan to solve the poor relief problem. We went so far in Calumet Township as to present to the county commissioners this proposition: that in the four major hospitals we would organize the various staffs into a rotating group and that we would undertake to take care of all hospital patients free of charge, including surgery and obstetrics; that we would have an out-patient department, the county commissioners to rent two or three more rooms in the hospital and put in competent help to take care of that end of it. House calls to be made for $1.00. Outside areas $1.50. They turned that down. In substitute we have a man in Gary to take care of all the work at $2,500 a month, $30,000 a year. Over in North Township we have a similar contract with Dr. Young at $2,500. Dr. Young has a man over in East Chicago, pays him $500 a month. Over in Whiting I don't know what his arrangement is, probably pays $200 or $250 a month. In Hammond he gives his work to three or four or five of the doctors. Very unsatisfactory arrangement in our township. Our indigents are not getting the proper attention. Under that contract system as it exists in our township I would say that the system is an absolute failure.

For 1933 we have arranged seven of our eight programs and we are leaving only one possible meeting for this poor relief proposition. We are thoroughly disgusted. We have offered to do it for nothing; they are paying two men $60,000 a year.

Eleventh District—Harrold—All counties are functioning; meet at least eight or nine times a year.

Twelfth District—VanBuskirk—We have the same troubles in our district as they have in the Tenth in regard to arranging with the township trustee for the care of the indigent sick. Our plans are not working out.

Reports of Officers

F. S. Crockett, retiring president, in making a verbal report on the year's work, stressed the positions of the different interorganizations of the parent state body, House of Delegates, Council, committees, etc., that in view of the House of Delegates meeting but once a year, the Council consisting of the district councilors, became by its nature and make-up the most important component part of the whole through its intimate personal relationship with each member in the district. He also called attention to the efficient work done by some committees, and the lack of interest and function by others caused by the indifference of committee chairmen. He spoke of the great value received for the small amount of dues, and said that he was greatly pleased with the co-operation received from all the members, and ended by saying, "I owe you a debt of gratitude, and I wish to make my parting word one of commendation, gratification and appreciation on my part."

J. H. Weinstein, the incoming president, spoke in high terms of the accomplishments of Dr. Crockett and the efficient manner in which he had conducted the society affairs, and mentioned activities started and the necessity and desirability of their continuance. He especially spoke of the important work before the Legislative and Health Insurance Committees in view of the meeting of the legislature and the report of the Committee on the Cost of Medical Care. He also expressed the thought for consideration of the multiplication of committees, and wondered if their overlapping duties could not be better handled with fewer or change of committees. He expressed his appreciation to the outgoing president for the opportunities afforded to get into intimate touch with all the association activities during his "novitiate" year, so that there should be a minimum of lost motion in the change of administration, and expressed his confidence in the same continued co-operation of all officers, committees and members as in the past.

E. E. Padgett, president-elect (1934): I am heartily in sympathy and very proud of the things that are being accomplished by the state association.

A. F. Weyerbacher, treasurer, gave the following treasurer's report:

(Since this meeting the treasurer's complete statement for the year 1932 has been submitted and is substituted.)

INDIANA STATE MEDICAL ASSOCIATION

Application of Funds January 1 to December 31, 1932

Income

Membership Dues, 2,720 members, (6-1931 memberships)	$19,040.00
Income from Exhibits	1,167.50
Interest on Checking Account	113.48
Interest on Liberty Bonds	212.50
Interest on Misc. Bonds	784.80
Postgraduate Study Committee	427.50
Indiana State Dental Association	12.00
Total income for period	$21,757.78

Expenditures		
Headquarters Office	$10,971.87	
Medical Defense	1,715.00	
Publicity Committee	370.66	
Journal	5,426.00	
Public Policy	100.56	
Postgraduate Study Committee	245.79	
Miscellaneous Committees	384.18	
Council	295.75	
Officers	150.00	
Annual Session	1,461.01	
Attorney	600.00	
Total Expenditures		21,720.82
Net income for the period Jan. 1 to Dec. 31, 1932		$36.96
Surplus at January 1, 1932		29,887.18
		$29,924.14
Less prepaid 1933 expense		$322.77
Surplus at December 31, 1932		$29,601.37
Analysis of Surplus Account at December 31, 1932		
Liberty Bonds (4¼%)		$5,000.00
Realty Bonds (6%)		5,000.00
State Highway Bonds (5%)		2,000.00
City Hospital Bonds (1 at 4¾%; 5 at 4%)		6,000.00
Flood Prevention Bonds (4¼%)		5,000.00
School Improvement Bonds (4½%)		5,000.00
Checking account balance at Indiana National Bank		1,401.37
Petty cash acct. bal. at Bankers Trust Company		200.00
		$29,601.37

INDIANA STATE MEDICAL ASSOCIATION

Comparative Statement of Income and Expenses for the Years of 1931 and 1932

	Year Ended Dec. 31, 1931	Year Ended Dec. 31. 1932	Increase or -Decrease
Income			
Dues, 2,720 members, (6-1931 members)	$19,369.00	$19,040.00	-$329.00
Exhibits	2,800.00	1,167.50	-1,632.50
Interest on Checking Acct.	113.62	113.48	-.14
Interest on Liberty Bonds	212.50	212.50	
Interest on Misc. Bonds	884.99	784.80	-100.19
Postgraduate Study Committee		427.50	427.50
Indiana State Dental Ass'n		12.00	12.00
Total income	$23,380.11	$21,757.78	-$1,622.33
Expenditures			
Headquarters Office	$11,867.01	$10,971.87	-$895.14
Medical Defense	1,065.65	1,715.00	649.35
Publicity Committee	520.29	370.66	-149.63
Journal	5,530.00	5,426.00*	-104.00
Public Policy	331.17	100.56	-230.61
Postgraduate Study Committee		245.79	245.79
Miscellaneous Committees	165.57	384.18	218.61
Council	235.06	295.75	60.69
Officers	217.75	150.00	-67.75
Annual Session	2,428.11	1,461.01†	-967.10
Attorney	400.00	600.00	200.00
Total expenditures	$22,760.61	$21,720.82	-$1,039.79
Net Income	$619.50	$36.96	-$582.54

†Prepaid 1933 expense of $290.25 not included in this figure.
*Prepaid 1933 expense of $32.52 not included in this figure.

On the motion of Dr. Romberger, seconded by Dr. Shanklin, this report was accepted as read.

E. M. Shanklin, editor of The Journal: Dr. Shanklin reported on the meeting of the Editorial Board held the evening preceding the Council meeting, at which time the plans for editing and publishing THE JOURNAL were gone over in great detail. "There will be no material change in editing THE JOURNAL. It will be published by William B. Burford Company in Indianapolis and will come out the first of the month. We are starting a new column entitled, 'The Voice of the Doctor,' the first article in which will be a contribution from M. A. Austin. I believe if we can get all the help that has been promised and some that is being asked for we will be able to give you a good Journal in 1933."

Unfinished Business

1. Formal report was made that the headquarters office has been moved to 1021 Hume-Mansur Building, with room for executive offices, Journal office, and small reading room where Journal exchanges will be available to physicians. This change in location is in accord with recommendation of the Council at its second meeting in Michigan City in September.

2. *Formal Contract Prepared and Signed by Dr. Shanklin and Council:*

"AGREEMENT

"THIS AGREEMENT entered into this first day of December, 1932, by and between INDIANA STATE MEDICAL ASSOCIATION, Party of the First Part, and DR. E. M. SHANKLIN, Party of the Second Part, witnesseth:

"That the First Party by these presents employs the Second Party, and the Second Party accepts such employment as Editor of THE JOURNAL of the Indiana State Medical Association. Said employment is on the following terms and conditions:

"1. The Firt Party will pay to the Second Party for his services as Editor the sum of $600.00 per year, which payments are to be made in twelve equal monthly installments of $50.00 each.

"2. THE JOURNAL shall be published by a publisher to be selected by the Executive Secretary of the First Party with the aid and advice of the Executive Committee of the First Party.

"3. The office of THE JOURNAL shall be in the headquarters office of the Indiana State Medical Association.

"4. The Executive Secretary of the First Party shall be the Managing Editor of THE JOURNAL and shall discharge such duties in the preparation and publication of THE JOURNAL as usually pertain to the Managing Editor of such publications.

"5. Miss Hope Toman, or any other person to be selected and appointed by the Council or the Executive Committee, shall be Assistant to the Editor and Managing Editor in the editing and publishing of THE JOURNAL, and shall perform such services as usually pertain to that position in the publication of similar journals.

"6. There shall be an Editorial Board of five members, no more than two of whom shall be from

any one Councilor District, the members of which Editorial Board shall be appointed by the Council of the First Party. This Editorial Board shall pass upon all matters of policy in regard to or involving THE JOURNAL and their determination of questions of policy shall be final, and the Second Party, as Editor of THE JOURNAL, will conform to the policies determined by the Council.

"7. The Editor and the Editorial Board shall review books sent in to THE JOURNAL and shall make proper provision that such books shall become permanently a part of the library of the Association.

"8. As Editor of THE JOURNAL the Second Party will have supervision in general of the preparation and assembling of the contents of each issue of THE JOURNAL and the matter of opening THE JOURNAL to articles and other material appropriate thereto, and of accepting or rejecting articles and material prepared and presented for publication, all of which shall be done under the direction and control of the Editorial Board.

"9. It is understood by the Parties hereto that THE JOURNAL is to be maintained and developed as the official professional Journal of the Indiana State Medical Association, devoted to the interests of the medical profession and the Association of which it is to be the official organ.

"10. This agreement shall be in full effect from January 1, 1933, to and including December 31, 1933, which shall be the term of employment covered by this contract.

"IN WITNESS WHEREOF, the First Party has executed this Agreement in duplicate by its properly authorized officers and the Second Party by his signature on the date above written.

INDIANA STATE MEDICAL ASSOCIATION.
By O. O. Alexander,
First Party.
E. M. Shanklin,
Second Party.

Suggestions and Proposals for 1933 Meeting at French Lick

1. *General outline of program.*

MONDAY, SEPTEMBER 25, 1933

8:00 a. m. Registration starts, exhibit hall, French Lick Springs Hotel.
9:00 a. m. Golf tournament, French Lick Springs Country Club.
12:15 p. m. Golfers' luncheon, French Lick Springs Country Club Clubhouse.
12:30 p. m. Council meeting, French Lick Springs Hotel.
2:00 p. m. Reception and tea for visiting women.
4:00 p. m. House of Delegates meeting, convention hall, French Lick Springs Hotel.
7:00 p. m. Stag dinner, basement of convention building French Lick Springs Hotel.
7:00 p. m. Party for women.

TUESDAY, SEPTEMBER 26, 1933

9:00 a. m. Scientific program.
Instructional courses:
Medical Section, main convention hall.
Surgical Section, north room.
Eye, Ear, Nose and Throat Section, basement of convention building.
10:00 a. m. Some sort of entertainment for women.
12:00 m. Luncheon bridge or some other entertainment for women.
2:00 p. m. Scientific program, general meeting, convention hall.
6:00 p. m. Fraternity, class and ex-service men's dinners, get-togethers and banquets.
8:00 p. m. Theater party for physicians, their wives and guests, convention hall.

WEDNESDAY, SEPTEMBER 27, 1933

7:00 a. m. House of Delegates breakfast, French Lick Springs Hotel.
9:00 a. m. Scientific meeting, sectional meetings.
2:00 p. m. Scientific meeting, general meeting.
7:00 p. m. Formal banquet with guest of honor speaker and final windup, French Lick Springs Hotel.

After a lengthy discussion the general outline of program was approved by the Council.

2. *Scientific exhibit.* It was moved by Dr. Hare, seconded by Dr. Ensminger and carried that the scientific exhibit be continued. Expense for this exhibit in 1932 was $123.66.

3. *Employment of professional medical stenographers.* Expense for 1932 meeting was $380.25. Expense probably will be higher at French Lick. On motion of Dr. Romberger, seconded by Dr. Shanklin and carried, this matter was referred to the Budget Committee with the recommendation that if the budget could stand it these services should be continued.

MEMBERSHIP REPORT

Indiana State Medical Association, November 30, 1932

County Society	Number M.D.'S. in County	Members Nov. 30, 1932	Members Nov. 30, 1931	Loss—Gain	Eligible Non-Members	New Members	Removed and Retired	Deceased	Ineligible
1st District—									
Posey	22	13	11	2	6		2	1	
Vanderburgh	141	94	100	—6	31		9	1	6
Warrick	21	6	5	1	14		1		
Spencer	20	9	10	—1	8		1	1	1
Perry	12	9	10	—1	2				1
Gibson	35	24	25	—1	2		6	2	1
Pike	12	6	7	—1	4		1		1
Total	263	161	168	—7	67		20	4	10
2nd District—									
Knox	59	29	31	2	25	1	4		
Daviess-Martin	31	22	24	—2	5		2	1	1
Sullivan	27	22	21	1	2	1	3		
Greene	25	14	12	2	6	2	1	3	1
Owen	12	8	8		1	1	1		2
Monroe	36	32	28	4	4	1			
Total	190	127	124	3	43	6	11	4	4

Membership Report—Continued

County Society	Number M.D's. in County	Members Nov. 30, 1932	Members Nov. 30, 1931	Loss—Gain	Eligible Non-Members	New Members	Removed and Retired	Deceased	Ineligible
3rd District—									
Lawrence	31	21	22	—1	4		6		
Orange	25	20	17	3	2	2	3		
Crawford	12	4	4		5		1	1	1
Washington	15	8	8		2		4		1
Scott	6	3	4	—1			2		1
Clark	25	17	17		7				1
Floyd	53	41	41		5	1	3	2	2
Harrison	14	5	6	—1	7	1	1		1
Dubois	21	15	15		4		2		
Total	202	134	134		36	4	22	3	7
4th District—									
Brown									
Bartholomew	33	23	23		4	2	3		3
Decatur	24	18	15	3	4	2	2		
Jackson	22	18	18		2				2
Jennings	12	10	11	—1			1		1
Ripley	21	13	16	—3	8	1			
Jefferson	25	17	17		1		6	1	
Switzerland	7	6	5	1		1			1
Dearborn-Ohio	25	17	18	—1	3		3		2
Total	169	122	123	—1	22	6	15	1	9
5th District—									
Parke-Vermillion	33	15	14	1	14		2	1	1
Putnam	21	16	17	—1	5				
Vigo	134	116	126	—10	6		5	3	7
Clay	23	16	19	—3	7	1			
Total	211	163	176	—13	22	1	7	4	8
6th District—									
Hancock	25	17	18	—1	3		3		2
Henry	38	25	27	—2	8		1	1	3
Wayne-Union	85	48	49	—1	16	3	7	4	11
Fayette-Franklin	28	22	20	2	1	4	4		1
Rush	26	20	21	—1	4			1	1
Shelby	33	18	16	2	12		3		
Total	235	150	151	—1	44	7	18	4	18
7th District—									
Hendricks	26	16	17	—1	5	1	4		1
Marion	777	482	482		217	21	20	18	40
Morgan	38	22	23	—1	9		4	3	
Johnson	28	11	11		10		2	3	2
Total	869	531	533	—2	241	21	30	24	43
8th District—									
Madison	97	60	61	—1	25		7	3	2
Delaware-Blackford	96	66	69	—3	16	1	4	5	5
Jay	27	11	13	—2	13		1	1	1
Randolph	33	20	23	—3	7		4	1	1
Total	253	157	166	—9	61	1	16	10	9
9th District—									
Benton	16	13	11	2		2	1		2
Fountain-Warren	27	18	19	—1	4		1	2	2
Tippecanoe	92	81	80	1	6	4	4		1
Montgomery	52	30	30		12	2	9	1	
Clinton	38	22	22		6	2	6	1	3
Tipton	18	10	9	1	5	1	3		
Boone	29	9	11	—2	12		3		5
Hamilton	30	23	21	2	4	3	2		1
White	21	6	9	—3	12		2		1
Total	323	212	212		61	14	31	4	15
10th District—									
Lake	252	169	188	—19	63	4	9	1	10
Porter	26	22	20	2	2	1	2		
Jasper-Newton	25	15	18	—3	8		2		
Total	303	206	226	—20	73	15	13	1	10
11th District—									
Carroll	21	19	18	1	1		1		
Cass	48	30	35	—5	11	1	1	3	3
Miami	35	21	21		13	1	1		
Wabash	34	26	25	1	4		2	2	
Huntington	35	24	24		5	2	3	1	2
Howard	46	32	36	—4	4		2	2	6
Grant	82	41	38	3	27	3	5	1	8
Total	301	193	197	—4	65	7	15	9	19

Membership Report—Continued

County Society	Number M.D's. in County	Members Nov. 30, 1932	Members Nov. 30, 1931	Loss—Gain	Eligible Non-Members	New Members	Removed and Retired	Deceased	Ineligible
12th District—									
Lagrange	16	8	12	—4	6		2		
Steuben	21	10	10		9	1	1	1	
Noble	25	23	22	1		2	1	1	
Dekalb	31	20	22	—2	7	1	3		1
Whitley	15	10	11	—1	2		2		1
Allen	203	140	143	—3	34	8	7	1	21
Wells	20	16	13	3	3	1			1
Adams	23	17	15	2	3	1	2		1
Total	354	244	248	—4	64	13	18	3	25
13th District—									
LaPorte	64	45	46	—1	10	1	8		1
St. Joseph	183	140	143	—3	18	8	8	5	12
Elkhart	86	74	76	—2	2	3	6	1	3
Starke	9				8				1
Pulaski	10	6	4	2	3				1
Fulton	20	12	16	—4	5			1	2
Marshall	32	16			12	2			4
Kosciusko	29	19	14	5	3	3	4		3
Total	433	312	299	—3	61	17	26	7	22

SUMMARY BY DISTRICTS

1st District	263	161	168	—7	67		20	4	10
2nd District	190	127	124	3	43	6	11	4	4
3rd District	202	134	134		36	4	22	3	7
4th District	169	122	123	—1	22	6	15	1	9
5th District	211	163	176	—13	22	1	7	4	8
6th District	235	150	151	—1	44	7	18	4	18
7th District	869	531	533	—2	241	21	30	24	43
8th District	253	157	166	—9	61	1	16	10	9
9th District	323	212	212		61	14	31	4	15
10th District	303	206	226	—20	73	15	13	1	10
11th District	301	193	197	—4	65	7	15	9	19
12th District	354	244	248	—4	64	13	18	3	25
13th District	433	312	299	13	61	17	26	7	22
Total	4106	2712	2757	—63	860	112	242	78	199

Total members, December 31, 1931 2766
(These figures are for eleven months only.)

The Council recessed for luncheon in parlor A, fifth floor, Indianapolis Athletic Club.

Certificate of merit presented to Dr. A. B. Graham, past president of the state association, by Dr. Alexander. This certificate had been prepared for presentation at the annual meeting of the association at Michigan City in September, but as Dr. Graham was ill the ceremony was postponed until this occasion.

Dr. Frank L. Rector, of the American Society for the Control of Cancer, spoke upon the possibilities of making a cancer survey in Indiana. He answered many questions in regard to similar surveys that have been made in Wisconsin and other states. Upon the motion of Dr. Weinstein, seconded by Dr. Austin and carried, this matter was tabled for the present.

Veterans' hospitalization. Dr. Crockett made a report on the work being done by the Liaison Committee of the American Medical Association and the American Legion upon veterans' hospitalization. "Since the state meeting we have had one meeting in Washington composed of Dr. Cary, Dr. Wright, Dr. Olin West and myself. We had a meeting with General Hines and followed that with Major Griffith. Hines was of the opinion that

since Congress had constructed a number of these hospitals purposely for the care of non-service connected disabilities, he could not ask the government to close them up. He felt that persons able to pay should not be taken care of. His idea of the factor of need was wholly out of line with our conception of it. . . . Gen. Hines agreed that we should be permitted to send in our statisticians to study the following problem. . . . The Veterans' Bureau through their releases have put out hospital cost of about $4.00 a day in the conduct of their hospitals. We attacked that statement because it put civilian hospitals and doctors in an unenviable position. . . . We wanted to have the privilege of going into the statistics of the federal government to get true figures in acute cases. We wanted permission to go into their figures and if necessary into their various hospitals to find out what it really cost them. . . . The government takes these patients in and keeps them a much longer period than we do in our hospitals. One man in high position said that it cost on an average of $25.00 for transportation to government hospitals. Total cost to the government was estimated $53.00 for a tonsillectomy. . . . If we are to go before Congress we are going to have to produce figures of cost in our home communities comparable to what it is going to cost the government. . . . It is possible that we may be asked in our communities to organize ourselves on a basis that we will agree with our home doctors and our community hospitals to give services of various kinds in these acute cases at a price that is comparable to the true cost to the government now. We hope to show that the government is paying far more for the truly acute care than it is costing in our own community. . . .

This report of mine is unsatisfactory to me in that it is not conclusive at all but merely a report of progress."

Mr. Danner and Mr. Miller of the Burford Printing Company were guests of the Council at the luncheon.

County Society Activities

Dr. Shanklin brought up the question as to whether or not dinner meetings were better attended than 8 or 8:30 meetings. Dr. Harrold pointed out that in Grant County physicians from outside of Marion attended dinner meetings much better than other kinds of meetings, while the reverse is true of physicians residing in Marion. LaPorte, St. Joe and Tippecanoe counties have dinner meetings. Dr. Kennedy reported that Shelby County had the following schedule, which had proved very satisfactory: meeting at 5, dinner at 6, adjournment at 8:30. He said that most of the meetings the rest of the winter will be devoted to the subject of medical economics. Dr. Ragsdale reported that Lawrence County dues were $20.00, members paying for their meals in advance.

There are no societies in Brown and Starke counties, but physicians in Starke County attend and are members of the LaPorte County Medical Society.

Annual Session of the American Medical Association at Milwaukee, June 12 to 16, 1933

Dr. Shanklin moved that the executive secretary be requested to attend this meeting at the expense of the association. Motion passed unanimously.

A. M. A. Scientific Exhibit

A letter from the A. M. A. was read concerning this exhibit and announcement made that applications can be obtained from Thomas G. Hull, director of the scientific exhibit of the American Medical Association, 535 North Dearborn Street, Chicago.

New Business

1. *Medical Registration Fee.* For President Crockett's recommendation on this, see minutes of the House of Delegates, October Journal, page 479. Excerpt from the report of the Reference Committee on the Reports of Officers, 1932 annual session, follows:

"Something should be done to control the invasion of non-graduates of medicine in this state. Every community of a state of any size has its problems. Experiences of other states show that an annual registration gives them a check on the 'floater'. While, as the president says, we are opposed to an annual registration fee, we would be better equipped to handle this situation if funds were available to conduct investigations and to prosecute cases. We feel that some action on this question should be taken by the Council."

Dr. VanBuskirk moved that the Council recommend to the president that he appoint a special committee to make a study of this matter. Motion seconded by Dr. Ensminger and passed.

2. *University Hospital Admittance.* In view of the fact that at different times the Council has had under consideration this subject, the following letter, written by Dr. E. T. Thompson, administrator of the Indiana University Hospitals, was brought to the attention of the members of the Council in order that they may have at first hand information concerning this subject:

"Your letter of October 31st addressed to Thomas A. Hendricks, secretary of the Indiana State Medical Society, has been referred to me.

The Indiana University Hospitals consist of three hospital units: the James Whitcomb Riley Hospital for Children, the William H. Coleman Hospital for Women, and the Robert W. Long general hospital for adults. All of the children admitted to the Riley Hospital are charity patients, and ninety per cent of the patients admitted to the other two institutions fall into that classification. A certificate from a physician stating the pertinent social and professional facts about the patient must be filed with the hospital before the patient can be accepted as a charity

case. All children admitted to the Riley Hospital are committed to the hospital through the court of the local community in which the patients reside. The parents must make application to the court. If the parents do not have a family physician who can complete the certificate the court has the privilege of appointing one or two examiners to determine whether or not the patient is a fit subject for the institution. The court itself, in these cases, determines whether or not the parents or legal guardians are financially able to pay the cost of medical and surgical care. By law, the judge is authorized to commit only the children whose parents or legal guardians are unable to pay for this medical and surgical care.

"Admissions to the Coleman and Long Hospitals must be recommended not only by a physician but also by some county official. If the patient is an entirely free case a certificate of indigence must be obtained from the trustee of the township in which the patient resides. Before the patient can be admitted, in every single instance, it is necessary that the judge's commitment order (for Riley patients) or the township trustee's order or any other certificate of admission be accompanied by a certificate from a physician. Only in rare instances, in the case of emergency patients, would a case be accepted without a physician's certificate, and even in these instances it is usual for a physician to call us by telephone and request admission for the patient. We feel that it is the physician's contact with the patient and his request to the institution that the patient be admitted that saves considerable abuse.

"I am sending you herewith copies of the James Whitcomb Riley Act, the commitment orders to the Riley Hospital, physician's report blank, and trustee and part pay certificates which govern admission to the Long and Coleman Hospitals.

"If there is any further information I can give you do not hesitate to call upon me for it."

This letter is a copy of one sent to the secretary of the Wayne County Medical Society of Detroit, Michigan.

In discussing this question Dr. Crockett said he thought that the law probably could be revised to some benefit to other sections of the state. Our community hospital's cost to our township," he said, "is two dollars per day. If trustee can get the patient admitted to the Long Hospital the township does not have to pay the two dollars but the county pays four dollars to the State hospital. Furthermore this change that would reserve the use of the state hospitals for those cases for which in small communities we have no one particularly trained. . . . As a state association we should have in mind some revision of that law."

Dr. Hare moved that this matter be referred to the Legislative Committee for study and action. Motion seconded by Drs. Romberger and Ensminger and carried.

3. Resolutions received from Fulton County and Cobb County (Georgia) Medical Societies asking that the state association adopt a resolution requesting the medical colleges of the United States to reduce the number of graduates each year until the law of demand and supply has been fully complied with. The resolution states that the number of graduates is to be determined by the national committee appointed by the president of the American Medical Association. Upon motion of Dr. Shanklin, seconded by Dr. Kennedy and carried, this matter was referred to the Committee on Medical Education and Hospitals.

4. *Comprehensive Study of Health Insurance.* Dr. Weinstein authorized by the House of Delegates to appoint such a committee. See October number of THE JOURNAL, pages 470 and 471.

Elections for 1933

Upon the motion of Dr. Ensminger, seconded by Dr. Hare and carried, the present members of the Executive Committee, Dr. William H. Kennedy and Dr. H. H. Wheeler, were re-elected for 1933.

Upon the motion of Dr. Shanklin, Dr. O. O. Alexander, of Terre Haute, was re-elected unanimously chairman of the Council.

Upon the motion of Dr. Hare, unanimously seconded, the secretary was to send Dr. Rogers, retiring councilor, a letter of appreciation for his long service as councilor of the Thirteenth District.

There being no further business, the meeting was adjourned.

THOMAS A. HENDRICKS,
Executive Secretary.

INDIANA STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

RESOLUTIONS

During the past year the Indiana State Medical Association has been bereft of two unusual personalities, Dr. Charles H. Good, and Dr. Albert E. Bulson.

Charles H. Good typified the general practitioner whose existence and influence must be preserved else the profession of Indiana will decline and fall. He liked people en masse, and wanted them all to be his friends. His almost universal success in this endeavor was due to the friendliness which he ever radiated. So well was he beloved by the rank and file, that he was rewarded by being elected to the presidency of the association in 1923. In turn he repaid the association by his influence in political and civic organizations in which he was a dominant factor.

Albert Eugene Bulson, in the past thirty years, impressed his characteristics and ideals upon the medical profession as few have ever done before him. He burned out in the intensity of his zeal for lofty medical standards. Careless of friend or foe, he forged the work at hand. He attained what to his mind was the highest position in the organization—not the presidency which he could have had at any time, and to which he was well entitled—but the editorship of his beloved JOURNAL, which he conceived, created and conducted with single-minded autocratic beneficence. His monument, more enduring than bronze, is the file of THE JOURNAL. Res ipsa loquitor. The volumes speak for themselves. The paper and the type are now cold, but the vitalizing influence of his editorials live on and will have a cumulative effect on a future generation of Indiana doctors who never knew him.

Farewell to two friends—friend who lived and died with one high purpose, and that to advance medical achievement and renown.

Signed:
C. N. COMBS, M. D.,
ERNEST RUPEL, M. D.,
F. T. ROMBERGER, M. D.,
T. B. RICE, M. D.,
PIERCE MACKENZIE, M. D.,
Editorial Board.

INDIANA STATE MEDICAL ASSOCIATION BUREAU OF PUBLICITY

November 15, 1932.

Meeting called to order at 3:30 p. m.

Present: W. N. Wishard, M. D., chairman; J. H. Stygall, M. D.; E. D. Clark, M. D., and T. A. Hendricks, executive secretary.

Minutes of the meeting of November 1 read and approved.

Newspaper release for publication in Tuesday morning papers, November 22, "A Word to Hunters," read and approved.

Radio releases:

Saturday, November 5—"So-Called Cancer Cures."
Saturday, November 12—"A Word to Hunters."

Representatives of a pharmaceutical company appeared before the Bureau of Publicity and the Bureau asked them to put their request in writing.

The following letter suggesting that publicity be given to the laity concerning appendicitis and its dangers was received from a physician:

"Several days ago I spoke to you about the necessity for more publicity to the laity concerning appendicitis and its dangers. Especially does this seem to be true during the present depression. About a year ago I summarized the facts concerning 200 consecutive cases of acute appendicitis coming to the City Hospital in the period previous to that time and found that 62, or 31 percent, had a ruptured appendix before they were operated, while 128 were operated before rupture had taken place. Of the 128, 1 died, while 23, or 37 percent, of those having a ruptured appendix died following operation and treatment.

"During this summer of 28 patients cared for on the white male surgical service at the City Hospital, 15 or 54 percent had a ruptured appendix before admission and operation, with a resulting unsatisfactory surgical mortality. Most of these patients had been sick 2 to 6 days and had taken many types of vigorous catharties before calling a physician.

"I have also been informed by several surgeons that the appendices they see now have a higher percentage of perforations than usual. This is undoubtedly a product of the depression because many people are trying to avoid calling a physician because of the expense.

"The mortality figures at the City Hospital are probably higher than the average mortality of ruptured appendices because of the very badly neglected cases sent there. However, everyone well knows the seriousness of a ruptured appendix both because of the mortality and the morbidity that results from it.

"I would, therefore, recommend that your publicity committee give consideration to these facts and address the public about the dangers of taking catharties when abdominal pain is present without consulting a physician."

Letter received from the director of the scientific exhibit of the American Medical Association thanking the Bureau of Publicity for forwarding the picture of the late Dr. Frank B. Wynn of Indianapolis who originated the scientific exhibit at the American Medical Association.

Letter received from the Indiana Congress of Parents and Teachers stating that that organization would be glad to receive releases from the Bureau of Publicity so they may be used as enclosures in the regular monthly bulletin of that organization.

The Bureau of Publicity put in a request to the Budget Committee for $500.00 for 1933. The books show that the appropriation and expenditures of the committee during 1932 were as follows (up to November 12, 1932):

Amount allowed by Budget Committee	$500.00
Expense	345.54
Balance	$154.46

The Bureau points out in its letter to the Budget Committee that the Bureau has been very economically conducted and will return any surplus at the end of the year.

Bulletin received from the Indiana Parent-Teacher Association entitled "Preserving Health Through Preventing Contagious Disease." The Bureau commends the Parent-Teacher Association for its program for guarding against contagious diseases and makes the suggestion that the bulletin should specify that physicians making the tuberculin tests mentioned in the bulletin should be skilled in doing so.

Pamphlet entitled "Information Regarding the Prevention of Contagious Diseases" received the final O. K. of the Bureau and the secretary was instructed to send it to the printers and prepare it for distribution through the county society secretaries.

The following bills were approved for payment:

Central Press Clipping Service	$5.00
Copy Papers, Inc.	4.80
	$9.80

There being no further business the meeting was adjourned.

The above minutes were approved in each separate part and as a whole November 23, 1932.

November 23, 1932.

Meeting called to order at 3:30 p. m.

Present: W. N. Wishard, M. D., chairman; J. H. Stygall, M. D.; E. D. Clark, M. D., and T. A. Hendricks, executive secretary.

Minutes of the meeting of November 15 read and approved.

Newspaper release for publication in Saturday morning papers, December 3, "Laxatives and Appendicitis," read and approved.

Newspaper release for publication in Saturday afternoon papers, December 10, "Campaign Against Appendicitis," read and approved. The Bureau suggested that this release along with a letter be sent to a selected group of officers and members of the state and local pharmaceutical associations.

Radio release:

Saturday, November 19—"Trouble Making Habits."

Report on medical meeting:

November 14, 1932—Gibson County Medical Society, Princeton, Indiana. "Bowel Obstruction," was the subject of the principal paper delivered.

Correspondence in regard to cancer survey brought to the attention of the Bureau. After carefully investigating the proposed Indiana cancer survey of the American Society for the Control of Cancer, the Bureau sees nothing objectionable to such activity here in the state. However, the Bureau desires to refer this whole matter to the Council of the Indiana State Medical Association.

The director of the Division of Public Health Nursing of the Indiana State Board of Health appeared before the Bureau of Publicity asking the Bureau to suggest topics and speakers for the district public health meetings that are to be held within the next few months in Indiana. The Bureau asked the director to place the request in writing, giving details in regard to the contemplated meetings.

The members of the Bureau to whom was referred the tentative draft of an act concerning the control of narcotic drugs made a verbal report before the committee. A summary of this was to be made at the next meeting of the Bureau.

The following bill was approved for payment:

A. B. Dick Company $3.50

There being no further business the meeting was adjourned.

The above minutes were approved in each separate part and as a whole November 28, 1932.

WOMAN'S AUXILIARY TO THE VIGO COUNTY MEDICAL SOCIETY

The Woman's Auxiliary to the Vigo County Medical Society met November seventh at the Woman's Department Club in

Terre Haute. This was an educational meeting with Mrs. J. V. Richart as chairman.

Mrs. C. R. LaBier told the story of the first abdominal operation which was performed by Dr. Ephraim McDowell on Mrs. Jane Todd Crawford of Kentucky. She also told of the project for a memorial to this pioneer heroine of surgery.

Following this, Dr. J. H. Weinstein, president-elect of the Indiana State Medical Association, talked on the "Economic Problems of the Practicing Physician." This was very interesting and gave us much food for thought in these times when "state medicine" is constantly threatening us.

At the conclusion of the meeting, tea was served.

Respectfully submitted,
MRS. STEPHEN C. BRADLEY.

CLINTON COUNTY MEDICAL SOCIETY

The Clinton County Medical Society met at the Coulter Hotel, Frankfort, December 1st, with Dr. L. L. Harding presiding. Upon roll call, the following members were noted present: Drs. M. F. Boulden, F. A. Beardsley, C. A. Burroughs, A. G. Chittick, L. L. Harding, J. S. Ketcham, C. A. Robison, J. A. VanKirk, and I. E. Carlyle.

Dr. Guy L. Bergen, dentist, was the guest of the evening. He presented a paper on "Cooperation between the Patient and His Dentist."

Minutes of the last meeting were read and approved.

Resolutions of respect following the death of Dr. Charles A. Zinn were read and a copy ordered sent to the widow, Mrs. Blanche Zinn.

The financial report of the secretary was read and ordered adopted and spread upon the minutes.

Election of officers for the following year resulted as follows: president, Dr. John S. Ketcham, Rossville; vice-president, Dr. F. A. Beardsley, Frankfort; secretary-treasurer, Dr. Ivan E. Carlyle, Sedalia. Drs. A. G. Chittick, J. A. VanKirk, and M. F. Boulden were appointed to serve as a board of censors for the ensuing year. Drs. A. G. Chittick and A. M. Boulden remained the Legislative Committee for 1933.

Respectfully submitted,
IVAN E. CARLYLE, M. D., *Secretary.*

LAKE COUNTY MEDICAL SOCIETY

The annual dinner meeting of the Lake County Medical Society was held at the Lyndora Hotel, Hammond, Thursday, December 8, 1932, Dr. Pugh presiding.

Following the dinner the current business was transacted, then the evening devoted to entertainment features. The application of Dr. Gorilla, via transfer from the St. Louis Medical Society, was read and referred to the Council. Ballot on the application of Dr. Benz, of Whiting, resulted favorably; he was declared duly elected.

The report of the secretary-treasurer for 1932 read and approved.

Dr. Pugh, the retiring president, presented the annual address which was very well received. He reviewed the many activities of our society during the past year, much of which had to do with the various economic problems so rife at the present time.

Dr. E. S. Jones, the president-elect, gave a report on the plans already made for our 1933 meetings, the greater part of which will be given over to guest speakers, many of whom have already accepted our invitations.

That inimitable leader of song, Dr. T. W. Oberlin, ably assisted by Mr. Jos. Dalton, of Gary, then took charge for a time and made the welkin ring with good, old-fashioned arias of days gone by.

Our own "Jimmy" White, without whose marvelous voice our annual dinners would not be so entertaining, sang two numbers, the latter being an old time ballad that was very graciously received.

Then came the introduction of our dinner guests, members of the Indiana legislature for 1933, together with Lake County's own congressman-elect, the Hon. William T. Schulte. Each guest responded with a short talk, their offerings being very friendly to our profession.

We were also honored with the presence of our genial executive secretary, Thomas A. Hendricks, who fitted in especially well with our legislative guests.

The last number of the program was presented by Frank Hitchcock, a professional entertainer. His offerings were well received.

Adjourned.

J. R. PUGH, *President.*
E. M. SHANKLIN, *Secretary.*

TRUTH ABOUT MEDICINES

NEW AND NONOFFICIAL REMEDIES

The following products have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association for inclusion in New and Nonofficial Remedies:

DIPHTHERIA TOXIN DILUTED FOR SCHICK TEST.—A diphtheria immunity test (Schick Test) preparation (New and Nonofficial Remedies, 1932, p. 395) marketed in packages of one vial containing 1 cc. of diluted diphtheria toxin, and in packages of one vial containing 10 cc. of diluted diphtheria toxin. Parke, Davis & Co., Detroit.

DIPHTHERIA TOXOID.—This diphtheria toxoid preparation (New and Nonofficial Remedies, 1932, p. 382) is also marketed in hospital packages of one vial containing 30 cc. of diphtheria toxoid. Parke, Davis & Co., Detroit.—(*Jour. A. M. A.*, November 12, 1932, p. 1691).

AMPOULES DEXTROSE (d-Glucose) 25 Gm., 50 cc.—Each ampule contains dextrose (d-glucose) (New and Nonofficial Remedies, 1932, p. 262) 25 Gm., in distilled water, to make 50 cc. Lakeside Laboratories, Inc., Milwaukee, Wis.

SOLUTION LIVER EXTRACT (LEDERLE) FOR ORAL USE.—A hydroalcoholic solution of an active principle of liver extract (Cohn's fraction G); 10 cc. containing active material obtained from 100 Gm. of liver (1 fluid ounce containing the active material obtained from 10½ ounces avoirdupois). Solution liver extract (Lederle) for oral use is used in the treatment of pernicious anemia. Lederle Laboratories, Inc., Pearl River, N. Y.—(*Jour. A. M. A.*, November 26, 1932, p. 1863).

FOODS

The following products have been accepted by the Committee on Foods of the American Medical Association for inclusion in Accepted Foods:

CRESCA CHOICEST SMYRNA LOCOUM FIGS NOT SULPHURED (Cresca Company, Inc., New York City).—Partially dried cooked Cresca Smyrna Locoum figs from Asia Minor.

(a) QUEEN OF KANSAS FLOUR (Bleached); (b) FARMER BOY FLOUR (Bleached); (c) COUNTRY GENTLEMAN (Bleached); (d) PERFECTION FLOUR (Bleached); (a) Monarch Milling Company, (b) (c) Farmers Wholesale Company, (d) Interior Flour Mills Company; subsidiaries of Commander-

Larabee Corporation, Minneapolis.—Hard winter wheat "straight" flour; bleached.

RUMFORD BAKING POWDER (Rumford Chemical Works, Rumford, R. I.).—A phosphate baking powder containing corn starch, sodium bicarbonate, monocalcium acid phosphate and 0.1 per cent dried egg white.

WHITE HOUSE BRAND UNSWEETENED EVAPORATED MILK (White House Milk Company, Inc., Manitowoc, Wis., manufacturer; The Great Atlantic and Pacific Tea Company, distributor).—An unsweetened, sterilized evaporated milk.

FOX'S BREAD (Edward Fox Baking Company, York, Pa.).—A white bread made by the sponge dough method.

HYLAC (Nestle's Milk Products, Inc., New York).—Spray dried homogenized mixture of milk, added milk fat and lactose, malted whole wheat extract (essentially dextrins and maltose) and a small quantity of iron citrate. The addition of prescribed proportions of Hylac to proper dilutions of cow's milk with water is claimed to produce formula preparations approximating human milk in percentages of fat, protein and carbohydrate and in caloric value.

MCCORMICK'S ENGLISH MUSTARD FLOUR (McCormick & Company, Inc., Baltimore).—Mustard flour prepared from English mustard. It is claimed to be for table and cooking use and for the home preparation of mustard plaster, poultice, foot bath and emetic.

GIBBS TOMATO JUICE (Gibbs and Company, Inc., Baltimore).—Canned tomato juice retaining in large measure the natural vitamin content of the raw tomato juice. It is claimed to be a good source of vitamins A and B and an excellent source of vitamin C.

DR. P. PHILLIPS FLORIDA FANCI-CUT GRAPEFRUIT SLICES (Dr. P. Phillips Company, Doctor Phillips, Fla.).—Canned sliced Florida grapefruit sweetened with sucrose and retaining in large measure the original natural vitamin content. It is intended for all the dietary and table uses of grapefruit.—(*Jour. A. M. A.*, November 19, 1932, p. 1780).

BORDEN'S EVAPORATED UNSWEETENED STERILIZED MILK—Peerless Brand (Spanish), BORDEN'S EVAPORATED UNSWEETENED STERILIZED MILK—Peerless Brand, BORDEN'S ST. CHARLES BRAND UNSWEETENED EVAPORATED MILK (Spanish), BORDEN'S ST. CHARLES BRAND UNSWEETENED EVAPORATED MILK (Nestle's Milk Products, Inc., New York).—Unsweetened sterilized evaporated milk.

LARABEE'S LITTLE PRINCESS SOFT WHEAT PATENT FLOUR (Bleached) (Larabee Flour Mills of the Commander-Larabee Corporation, Minneapolis, Minn.).—A soft winter wheat patent flour; bleached. The flour is claimed to be especially designed for pastry and cake baking.

AMERICAN LADY TOMATO JUICE (American Packing Corporation, Evansville, Ind., manufacturer; Haas-Lieber Grocery Company, St. Louis, distributor).—Canned tomato juice which retains in large measure the vitamin content of the raw juice used. It is claimed to be a good source of vitamins A and B and an excellent source of vitamin C.—(*Jour. A. M. A.*, November 19, 1932, p. 1863).

ACCEPTED DEVICES FOR PHYSICAL THERAPY

The following have been accepted by the Council on Physical Therapy of the American Medical Association for inclusion in its list of accepted devices for physical therapy:

EVEREADY TABLE MODEL CARBON ARC LAMP, TYPE M-1.—The Eveready Table Model Carbon Arc Lamp is designed to produce a light approximating natural sunshine for use in the home or for individual therapeutic light treatment under the direction of a physician. The lamp is a portable model. Model M-1 is designed for operation on direct current or 60 cycle alternating current at standard household voltage. Model M-2 is the same as Model M-1 except that it is adapted to operation on 25 cycle alternating current and should not be used on direct current or 60 cycle alternating current. The Eveready Table Model Carbon Arc Lamp with Eveready Sunshine Carbons is claimed to provide ample ultra-violet radiation at a distance of 3½ feet with Corex filter in place to prevent rickets and aid in the promotion and development of sound bones and teeth when calcium metabolism is at fault, and that with the use of various impregnated carbons, it will deliver sufficient ultra-violet, visible and infra-red radiations for individual treatment at home under the direction of a physician practicing artificial light therapy. National Carbon Company, Inc., Cleveland.

DIET-O-METER.—The Diet-O-Meter is a balance (not spring scale) designed for weighing food and calibrated in grams and ounces. For ease of carrying, this scale is enclosed in a nickel-plated metal case 4¾ inches by 4½ inches in length and breadth, and seven-eighths inch in thickness. Technical Equipment Corporation, 120 Broadway, New York.—(*Jour. A. M. A.*, November 5, 1932, p. 1604).

PROPAGANDA FOR REFORM

STATEMENTS ON CONSTIPATION IN LAY ADVERTISING FOR ROUGHAGE FOODS AND BRAN.—The Committee on Foods reports that constipation may be due to causes other than those of dietary or "roughage" origin. Advertising to the laity shall refer to constipation due to insufficient roughage or food essentials only. Cases of constipation not yielding to the regular ingestion of foods providing considerable roughage should be under the care of a competent physician. A permissible claim for a roughage food follows: "Constipation due to insufficient roughage in the diet should yield to... eaten regularly. A competent physician should be consulted for cases not corrected in this simple manner." Wheat bran has laxative value. Whole grain cereals, and vegetables and fruits in general, are excellent sources of roughage. Bran itself may be irritating to sensitive bowels, the indigest-

ible cellulose of vegetables and fruits is much less irritating.—(*Jour. A. M. A.*, November 5, 1932, p. 1605).

JAEGER'S BUTTER-NUT BREAD NOT ACCEPTABLE.—The Oswald Jaeger Baking Company, Milwaukee, submitted to the Committee on Foods a white bread called "Jaeger's Butter-Nut Bread," prepared by the straight dough method. The baking formula contains neither butter, nuts nor butternuts. The name is therefore considered inappropriate, misinformative and misleading. The manufacturer when informed of this opinion expressed himself as unwilling to change the name in accordance with the Committee's recommendation. This bread, therefore, cannot be listed among the Committee's accepted foods.—(*Jour. A. M. A.*, November 5, 1932, p. 1605).

SIESE'S GENUINE BUTTER-NUT BREAD NOT ACCEPTABLE.—The Grays Harbor Baking Company, Aberdeen, Wash., submitted to the Committee on Foods a white bread called "Siese's Genuine Butter-Nut Bread" prepared by the straight dough method. The baking formula contains neither butter, nuts nor butternuts. The name is therefore considered inappropriate, misinformative and misleading. The label statement "Pure milk used" implies that milk is the liquid ingredient of the baking formula used in the preparation of the bread dough. This is not true, as only a relatively small proportion of a milk product is used in the formula. Another statement, "Rich as butter" signified that the bread is equivalent to butter in nutritional and caloric values. Both these claims are incorrect, inappropriate, misinformative and misleading. The manufacturer when informed of these opinions has not shown willingness to change the name or eliminate the inappropriate label statements. This bread, therefore, cannot be listed among the Committee's accepted foods.—(*Jour. A. M. A.*, November 5, 1932, p. 1605).

QUACKERY AND PHYSICAL THERAPY.—A quack is generally defined as a person who makes claims for skill that he does not possess, especially medical skill. The quack in the field of physical therapy, as is pointed out by Dr. C. B. Heald, is more likely to make the claims for the machines than for his particular ability in operating the machines. In his consideration of this subject, Dr. Heald has set down certain limitations to determine who are qualified to practice physical therapy either as physicians or as lay technicians. He recognizes that no lay technician should use such devices on the sick without medical prescription and without repeated supervision of the patient by the physician. The responsibility for the care of the patient is not that of the technician but that of the doctor whom the patient consults. Heald feels that all physicial therapeutic measures in the hospital should be under the control of one department, not with light treatment in the department of dermatology, massage in the department of orthopedic surgery, and the electrical devices for stimulating nerves and muscles in the department of nervous and mental diseases or in the radiologic department. The American medical profession has its own Council on Physical Therapy, which already has contributed largely to the control of charlatanism in this field and which, as it gains momentum, will probably do even more effective work in this direction.—(*Jour. A. M. A.*, November 5, 1932, p. 1606).

GRAYBAN.—"Grayban," put out by Grayban, Inc., of New York City, is apparently a newcomer to the cosmetic field. An advertisement in the September *Good Housekeeping* declares that Grayban is "the miraculous discovery of a great scientist" who for years "labored to find a way to bring back natural color to the hair." A full-page advertisement of Grayban appearing in the August 6 issue of the *New Yorker* tells the public that Grayban is "the miraculous discovery of Carmelita Gomez, who, from far-off Trinidad, brought us this native secret." A specimen of Grayban was purchased on the open market—"regular price" $5.00; "for a limited time," $2.00! It consisted of two small bottles of modernistic design. One bottle, with a red rubber cap, contained a yellowish liquid; the other, with a black cap, contained a dark brown liquid. The A. M. A. Chemical Laboratory reported that qualitative tests on the lighter-colored fluid indicated the presence of thiosulphate, probably present as sodium thiosulphate. Sodium thiosulphate is a chemical reducing agent, being most commonly known as the "hypo" of the photographers' developing room. The Chemical Laboratory also reported that qualitative tests on the dark fluid, showed the presence of a bismuth compound. Thus the "miraculous discovery" of either Carmelita Gomez or the "great scientist" seems to be nothing more wonderful than another one of the bismuth hair dyes. Obviously the claim that it will "bring back natural color to gray hair," is false. However, in order to demonstrate this point, gray hairs were obtained from individuals whose hair originally had been, respectively, reddish, brown and black. All of these specimens of gray hair were subjected to the Grayban dye—and all of them took on the same color!—(*Jour. A. M. A.*, November 5, 1932, p. 1622).

SULPHARSPHENAMINE: ITS USES AND LIMITATIONS.—For some years the Council on Pharmacy and Chemistry has considered the question of the high incidence of untoward reactions from sulpharsphenamine as compared with other arsphenamines. In 1925 a paragraph of warning was included in the description of the drug appearing in the current edition of New and Nonofficial Remedies. Recently question was raised as to whether, in view of the admitted danger from the use of sulpharsphenamine, it should no longer be recognized by description in New and Nonofficial Remedies. In order to obtain guidance in the matter, the Council sent a questionnaire to sixty-one dermato-syphilographers in the United States. In

answer to the first question: "Do you regard sulpharsphenamine as more toxic than the other arsphenamines?" 42 answered "yes," and 9 "no." To the second question: "Are you continuing the use of sulpharsphenamine in your clinic?" 16 answered "yes"; 9 replied that they were using it in a very limited manner; 27 answered "yes." To the third question: "Do you believe that the Council on Pharmacy and Chemistry would be justified in withdrawing this preparation from further recognition in New and Nonofficial Remedies, because of its greater tendency to dangerous reactions?" 28 answered "yes," 2 gave a questionable answer, and 22 answered "no." In view of the diversity of opinions and the considerable group of men who still feel that sulpharsphenamine has a place in the treatment of syphilis, the Council decided for the present to retain sulpharsphenamine in New and Nonofficial Remedies but to revise the description of the drug to give a more detailed warning concerning the dangers and limitations of its use.—(*Jour. A. M. A.*, November 12, 1932, p. 1688).

LUPULIN-AGAR, SIMARUBA-AGAR, SUMBUL-AGAR, TANNIN-AGAR AND GAMBIR-AGAR NOT ACCEPTABLE FOR N. N. R.—The Council on Pharmacy and Chemistry reports that a series of agar preparations, each stated to be "impregnated" with a preparation of a stated drug, is marketed by the Reinschild Chemical Company, New Rochelle, N. Y. Among these are Lupulin-Agar, stated to be "Agar impregnated with Lupulin, 100 gm. containing 3.25 gm. Lupulin"; Simaruba-Agar, stated to be "Agar impregnated with Simaruba, 100 gm. containing 100 cc. of a 20 per cent tincture of Simaruba"; Sumbul-Agar, stated to be "Agar impregnated with Sumbul; 100 gm. containing 100 cc. fluid extract Sumbul; U. S. P." though no preparation of Sumbul is the U. S. P. X; Tannin-Agar, stated to be "Agar impregnated with Tannin; 100 cc. containing 3.25 gm. Tannin"; and Gambir-Agar, stated to be "Agar impregnated with Gambir, 100 gm. containing 200 cc. Tinctura Gambir Composita, U. S. P." The Council declared Lupulin-Agar, Simaruba-Agar, and Sumbul-Agar not acceptable for New and Nonofficial Remedies because the use of lupulin, simaruba and sumbul is not justified, and declared Tannin-Agar and Gambir-Agar unacceptable because agar is not an acceptable vehicle in the treatment of irritative conditions of the gastro-intestinal tract, and because the dosage of the astringents in these fixed-ratio preparations appears to be inadequate.—(*Jour. A. M. A.*, November 12, 1932, p. 1690).

HEPATEX P. A. F. NOT ACCEPTABLE FOR N. N. R.—The Council on Pharmacy and Chemistry reports that Hepatex P. A. F. (Evans Sons, Lescher & Webb, London, England; Thomas A. Hedley, New York, American agent) was submitted for the Council's consideration as another liver preparation for intravenous and subcutaneous administration in the treatment of pernicious anemia. It is stated that 5 cc. of the preparation represents 100 gm. of mammalian liver. The information supplied concerning the preparation of the product appeared to be in most respects consistent with the methods described by Cohn et al. for purifying liver extracts suitable for intramuscular and intravenous administration; however, the statement is made from the watery extract "the protein matter and other inactive constituents are removed by a special secret process," and no further information as to this process was supplied. The firm was informed that the product might be made acceptable (a) if the proprietary name was replaced by a descriptive name, such as "Liver Extract for Intramuscular Use"; (b) if the recommendation for its intravenous use was discontinued or convincing evidence of its safety submitted; (c) if the objection to the "secret process" was removed, and (d) if the claim in the advertising circular that the product is recognized all over the world as "the best preparation of its kind" was abandoned. In its reply the firm stated that its product has been used in some hundreds of cases without a report of untoward effect; that it is not willing to disclose the details of the "secret process" by which the product is obtained. The firm has not indicated willingness to withdraw the claim "the best preparation of its kind." The Council declared Hepatex P. A. F. unacceptable for New and Nonofficial Remedies because it is marketed under a proprietary, insufficiently descriptive name without adequate declaration of composition, because there is no adequate evidence for the safety of the recommended intravenous use, and because the claim that the product is "the best preparation of its kind" is unwarranted.—(*Jour. A. M. A.*, November 12, 1932, p. 1690).

IODIZED SALT, AND GOITER AN IODINE DEFICIENCY DISEASE.—Iodine, an essential chemical element for normal nutrition, may be insufficiently furnished by food and drink and cause simple goiter, an iodine deficiency disease. Although supplemental iodine supplied through salt or other special foods may prevent goiter that would otherwise occur or cure incipient cases, the simple administration of iodine in this manner is not a "cure-all." An "accepted" iodized salt shall contain one part of sodium or potassium iodide for each 5,000 parts of salt (approximately 150 parts of iodine per million parts of salt), or the iodine equivalent of any other suitable iodine compound. Iodized salt containing more than this quantity is considered a medicament not to be advertised to the public for table and cooking uses.—(*Jour. A. M. A.*, November 12, 1932, p. 1691).

VITAMIN CLAIMS IN FOOD ADVERTISING.—Indefinite or general vitamin claims are vague, noninformative and misleading and do not permit a distinction between foods as sources of the respective vitamins. Vitamin claims shall stipulate the specific vitamin or vitamins present. It is desirable that warranted vitamin claims be expressed in appropriate terms indicative of the relative potency

of the food as a source of the vitamins in the dietary schedule. Foods may be considered relatively as fair, good and excellent or rich sources of vitamins.—(*Jour. A. M. A.*, November 12, 1932, p. 1691).

VAGUE MINERAL CLAIMS.—Vague or nonspecific "mineral" claims or statements in food advertising may, either directly or indirectly, signify or imply the presence of all the nutritionally valuable mineral elements in physiologically significant quantities in the advertised foods. "Mineral" claims should name those elements only which are contributed in substantial physiologic amounts by the respective foods in the quantities ordinarily consumed in the diet.—(*Jour. A. M. A.*, November 12, 1932, p. 1691).

TRICHOPHYTON EXTRACT (METZ TRICHOPHYTIN).—The Council on Pharmacy and Chemistry reports that Trichophyton Extract (Metz Trichophytin) is a mixture of the filtrates of various species of trichophyton submitted for consideration of the Council by the H. A. Metz Laboratories, Inc. The commercial product is stated to contain the "Extract of various species of trichophyton mixed in the proportion of approximately 40 per cent T. gypseum, 20 per cent cerebriforme, 20 per cent T. microides, 20 per cent T. rosaceum, violaceum and crateriforme in equal parts." From the report of Culzberger and Wise, it would seem that trichophyton extract is of some value in diagnosis and in treatment of certain cases, in the hands of certain individuals; but apparently the technic is difficult, and some patients may be seriously harmed by inexperienced practitioners. Two dermatologists, consultants of the Council, were asked as to (1) their opinion as to the value of Metz Trichophytin in diagnostic procedures, (2) whether they had observed any false positives, and (3) whether they could recommend it for therapeutic purposes. The first consultant replied that the value of Trichophytin Extract as a diagnostic means has not been established; that he had not worked with this preparation at all extensively and could not report any personal experience, and that he could not recommend it for therapeutic purposes. The second consultant replied that he believed that Trichophytin is of distinct value in the study of ringworm infections and that reactions sometimes give a clue as to the cause of eczematous eruptions; that he had obtained many reactions where it was believed that there was no active trichophytosis; that he had had an apparent cure of ringworm of the beard under trichophytin, but that its therapeutic possibilities need further study. Since there appeared to be a disagreement as to the value of Trichophyton Extract (Metz Trichophytin), the Council postponed consideration of the product to await the development of further clinical evidence from American dermatologists and authorized publication of a preliminary report.—(*Jour. A. M. A.*, November 19, 1932, p. 1779).

ALKA-SELTZER.—The Miles Medical Company of Elkhart, Ind., have been known for years the exploiters of the "Miles Nervine," a bromide mixture. Within the last year the same concern has been exploiting and advertising heavily "Alka-Seltzer Tablets," described as "effervescent alkaline tablets." The entire trend of the advertising is to give the impression that Alka-Seltzer Tablets are simply a mild effervescent alkaline preparation. The American Medical Association Chemical Laboratory analyzed it, and concluded that each Alka-Seltzer Tablet would be equivalent to 4.4 gr. acetylsalicylic acid; 0.4 gr. salicylic acid; 17.8 gr. citric acid, and 28 gr. sodium bicarbonate. It appears then, that the "sparkling alkaline drink" that is produced by dissolving two tablets of Alka-Seltzer in a glass of water, as suggested on the trade package, will contain nearly nine grains of aspirin (acetylsalicylic acid) and nearly one grain of salicylic acid in an effervescent mixture of citric acid and baking soda. A person who might follow the directions and take sixteen tablets a day, would consume over seventy grains of acetylsalicylic acid (aspirin) and over six grains of salicylic acid in that period, together with the effervescent ingredients citric acid and baking soda.—(*Jour. A. M. A.*, November 12, 1932, p. 1709).

ADEX TABLETS.—The Council on Pharmacy and Chemistry found Squibb Adex Tablets not acceptable for New and Nonofficial Remedies. The implications referred to in an advertisement in the *Parent's Magazine* for September are definitely misleading. The Council has declared there is no evidence to show that vitamin A will prevent any of the respiratory diseases mentioned in the advertisement. It would appear that E. R. Squibb & Sons is advertising the accepted product cod liver oil to the profession with conservative claims and that Adex Tablets are being advertised to the public with claims that are not countenanced by conserative medical opinion.—(*Jour. A. M. A.*, November 12, 1932, p. 1712).

"GAN-AIDEN," OR SOUVENIR SYNTHETIC, NOT ACCEPTABLE FOR N. N. R.—"Gan-Aiden" (formerly Souvenir Synthetic) is marketed by the Fantazn Laboratories, Los Angeles, as "A Powerful Local Anesthetic for Minor Surgery." No statement of composition appears on the trade package or in the advertising. An inquiry addressed to the firm, concerning Souvenir Synthetic, brought the information, "The base of our product is Benzocaine in an inert vehicle." The A. M. A. Chemical Laboratory reported that qualitative tests indicated the presence of ethylaminobenzoate (benzocaine) and an undetermined organic solvent. "Gan-Aiden," or Souvenir Synthetic, thus represents only another case of exploiting a well known drug in a preparation of undeclared composition, under a noninforming proprietary name. The Council declared it unacceptable for New and Nonofficial Remedies.—(*Jour. A. M. A.*, November 26, 1932, p. 1863).

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ORIGINAL ARTICLES

SYMPOSIUM: THE COMMON COLD*
VIEWPOINT OF THE OPHTHALMOLOGIST

J. R. GILLUM, M. D.
TERRE HAUTE

A discussion of "The Common Cold" from the standpoint of the ophthalmologist is not without difficulties. There are several diseases whose similarity is such that they are considered by many as colds or at least forms of colds. Most all of these diseases affect the eye. However, if the discussion is to be maintained within reasonable bounds, the subject should be concrete and the similar diseases excluded irrespective of objections.

To follow this plan necessitates defining "The Common Cold." St. Clair Thomson, discussing common colds and sequelae before the section of laryngology of the Royal Society of Medicine, defined a common cold as "An acute or subacute catarrhal affection commencing in the nose or postnasal space, generally invading the sinuses and sometimes spreading to the eustachian tubes, the pharynx, the larynx, or further. It may leave a chronic condition locally or elsewhere." He does not think influenza, primary pharyngitis, laryngitis or bronchitis, spasmodic rhinitis, asthma or primary sinusitis should be confused with colds.

The effects of a common cold are many and far-reaching—so far reaching that often the terminal affection is so many times removed that the cold or primary affection is frequently lost sight of. In such a case it is difficult to determine whether the terminal affection should be discussed as a sequela to an intermediate affection or the primary affection. The effects of colds upon the eye is a fair example. They are usually secondary to sinusitis. While sinusitis is not always the result of a cold it so often is that a discussion of the effects of this disease upon the eye and orbit should be included in this symposium.

Contrary to the opinion prevalent among the laity, the writer does not believe one catches cold in his eye, but does admit that there are ocular affections which are complications or sequelae of colds. It is not uncommon for an attack of iritis, iridocyclitis, or inflammatory glaucoma to be precipitated by exposure to cold, such as driving without wind protection or working out of doors on a blustery cold day. Of course, the cold was not the actual cause of the disease but acted only as an irritant.

It is hardly within the scope of this paper to discuss the etiology of colds, but a word has to be said in order to explain why some colds are prone to cause ocular complications and others are not. Three theories are given which attempt to explain the cause of colds:

A. Atmospheric causes, changes in temperature and cold.
B. Disturbance of metabolism.
C. Infection.

If it is possible to accept A and B as the etiology of a type of colds, then this type would be colds that do not affect the eye. Colds then that are caused by infection do cause ocular affections.

Pathways for infection to travel from the nose to the eye can be demonstrated anatomically. Part of the blood of the middle turbinate, inferior turbinate and septum is returned by way of the ethmoidal veins which communicate with the ophthalmic vein. This venous route is one pathway for infection to travel to the eye. Another, and probably the most usual way for infection to pass from the nose to the eye, is by extension from the paranasal sinuses and by way of congenital dehiscences in the bony structure separating the orbit and sinuses. The lamina papyracea, on account of its thinness, is a poor barrier against an infected ethmoid. The proximity of the posterior ethmoid cells and sphenoid sinus to the optic nerve is responsible for retrobulbar optic neuritis.

The agger nasi cells endanger the lacrimal sac and nasolacrimal duct. Schaeffer states that there is little definite knowledge regarding the lymphatics of the paranasal sinuses, but the lymph drainage seems to be into the retropharyngeal nodes.

Acute purulent conjunctivitis, commonly called by the laity "pink eye" or "cold in the eye," is

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an infection by one of the bacteria common to colds, but is the result of other causes more frequently than a cold in the head. Occasionally a patient will give a history of having had a cold recently. In such cases the infection very likely was transmitted from nose to eye by handkerchief or hands. Red, watery eyes that so frequently accompany colds are the result of nasal blockage.

While the etiology of dacryocystitis is not thoroughly understood, it is reasonable to believe some cases are the result of infection blown up the duct during a cold and agger nasi cell infection. The writer believes that chronic and not acute infection of the agger nasi cells is responsible for dacryocystitis, and on that account dacryocystitis should be considered a sequela to this disease instead of a cold.

It is not uncommon for a cold to cause an attack of iritis, but it is unlikely that it is more than an exciting cause, the true cause being a focal infection that has to be dealt with before a cure is obtained.

Ocular rheumatism characterized by painful rotation of the eyeballs, deep-seated orbital soreness and aching of eyeballs after doing close work for a short time, during or immediately following a cold, is the effect of toxins from the posterior ethmoid upon the extra-ocular muscles, and is relieved by intranasal treatment and the administration of salicylates.

Because of threatening blindness, the gravest sequela to a cold the oculist is confronted with is retrobulbar optic neuritis. While at times infection of any or all of the sinuses may be the cause of this disease, sphenoiditis and posterior ethmoiditis are most frequently responsible. The sphenoid sinus is in close proximity to the optic foramen and nerve, separated at times by only the thinnest bone. The most posterior ethmoid cells will at times overlap or partially surround the optic nerve. The anterior ethmoid cells play their rôle by infecting the posterior cells. If the pneumatization of the frontal and maxillary sinuses extends well posteriorly these sinuses, too, come into close proximity to the nerve and their disease will affect it.

The posterior vein of Vossius enters the optic nerve in the optic foramen, and occupying the center of the nerve passes back to the chiasm. This vein is made up of tributaries from the nose and posterior parts of the orbit, and is a direct route for infection from the nose to the nerve, particularly the papillomacular bundle.

Luther C. Peter and several others place such great stress upon sphenoiditis and posterior ethmoiditis as a cause of retrobulbar optic neuritis that they advocate opening the sinuses, even though no disease is shown by the usual diagnostic procedures.

Orbital inflammation, cellulitis and orbital abscess is frequently the result of sinusitis, especially ethmoiditis. It follows acute, as well as chronic, sinusitis. On account of the character of the bony structure it occurs most frequently in the young. It has been the writer's observation that orbital inflammation in adults usually follows chronic sinusitis.

It is common for pain caused by sinusitis to be referred to the eye and orbit. The exposed position of the sphenopalatine ganglion and its close proximity to the sinuses, especially the posterior ethmoid cells and sphenoid and the distribution of its sensory root fibers, explain this. It is not uncommon for a patient with posterior ethmoidal inflammation to consult an oculist on account of severe pain in his eye.

Infections of the cornea are usually the result of trauma or are secondary to conjunctival infection. Keratitis profunda and dendritic keratitis are possible exceptions, frequently being caused by focal infection which, of course, includes sinusitis.

Abducens paralysis is most frequently caused by syphilis, tabes, and tuberculous meningitis; likewise, oculomotor paralysis and trochlear paralysis. However, these nerves enter the orbit through the sphenoidal fissure and are so situated that they are not uncommonly affected by sinus disease, especially ethmoiditis. The following distinctive signs of orbital paralysis, as given by Posey and Spiller, are of interest: "The paralysis is usually unilateral. It frequently affects a single muscle. A total oculomotor paralysis with completely intact fourth and sixth nerves is rarely, if ever, orbital. Paralysis of all three motor nerves of the eye, without involvement of the cranial nerves except the first branch of the fifth, is almost certainly orbital or foraminal in origin."

Other ocular conditions caused by focal infection might be included in this discussion, but have been omitted because they were considered far removed from the subject, "The Common Cold."

SYMPOSIUM: COMMON COLD
VIEWPOINT OF THE OTORHINOLARYNGOLOGIST

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The disease entity, the common cold, is an acute inflammation of the mucosa of the upper air tract, usually beginning as an acute rhino-naso-pharyngitis. It may affect only this region, in which case it constitutes a mild, uncomplicated cold lasting from three to seven days; or it may extend to the sinuses, pharynx, larynx, the tracheobronchial tree or to the eustachian tubes and tympanic cavity. It may, also, invade more dangerous regions, frequently involving the mastoid process, the meninges, the brain, the various cra-

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nial blood sinuses and the jugular vein. Frequent attacks of colds often result in chronic foci of infection in the sinuses, tonsils, ears or glands of the neck and mediastinum, which immediately or later in life bring on the long train of regional or general focal diseases.

Symptoms. The symptoms of a cold are so well known that they need to be discussed only briefly. Usually there is a feeling of burning or rawness in the naso-pharynx, or it may begin with nasal stuffiness, chilliness, sneezing, increased secretion and lacrimation. There is impairment of the taste and olfactory senses. If the attack is uncomplicated, it is a mild cold and is soon over. If severe, it means an extension to the sinuses or to some other part of the upper respiratory tract. In the latter case there are constitutional symptoms of lassitude, headache, aches and pains over the body, especially the back and legs. In the severe types, the attack is likely to be diagnosed as "flu" or "grippe," and where many in the community suffer at the same time the condition is known as epidemic influenza.

Anatomy and Physiology. As the anatomy and physiology of the nose bears such important relationship to a study of the common cold, they will be briefly reviewed.

The internal nasal cavity is divided into fossae by the nasal septum which is further extended by the nasal meatuses and paranasal sinuses. Additional surface area is given by the turbinate bodies.

The lining membrane deserves special attention inasmuch as this structure is primarily involved in the inflammation and vitally important in clearing up the condition. Conforming to the double function of the nose, there are two areas of lining mucous membrane that differ in structure—the respiratory and olfactory parts. The latter is a small area occupying the anterior, superior portions of each nasal cavity and is unimportant in the study of a cold.

The respiratory mucous membrane is a ciliated, stratified, columnar epithelium varying in thickness in different parts of the fossa, being several millimeters thick over the inferior turbinates and the lower part of the middle turbinates as well as adjacent parts of the septum. Elsewhere it is less than one millimeter in thickness. This epithelium rests on a cribriform basement membrane. Ciliated cells extend the entire thickness of the epithelium, the slender ends being deeply placed and resting upon the basement membrane and the more bulky ends with the cilia attached forming the free surface. The cilia attain a length of from 5 to 7 micros and produce a definite and characteristic current toward the posterior nares. This explains why a drainage posteriorly obtains even in anterior sinusitis. Proetz has filmed successfully the living active cilia under low and high power magnification and has demonstrated that the cilia act in groups forming waves that travel toward the naso-pharynx. When active, the cilia strike in a certain definite manner at the rate of 60 to 70 times per minute and very energetically drive the bits of mucus or foreign substances rapidly along the surface of the epithelium. In the sinuses the direction of the ciliary waves is toward their ostia. The action of the cilia is very important in repelling a nasal infection and in treating a head cold; substances that inhibit their action should not be used.

Many mucus-forming goblet cells are found between the ciliated cells. The submucous layer or tunica propria consists of loose fibro-elastic tissue rich in mucous glands and collections of lymphocytes suggestive of lymphoid tissue.

The nasal respiratory mucous membrane is extremely rich in blood supply. The arteries branch to form a capillary network beneath the epithelium and around the mucous glands. From this capillary network the blood flows into a superficial venous plexus, thence into a deeper one. These blood lakes assume the character and rôle of erectile tissue controlled by circular and longitudinal bundles of unstriped muscle imbedded in their walls. Nerve reflexes from the spheno-palatine ganglion control the filling and emptying of these blood lakes and probably have much to do with ciliary action.

The physiological function of the nose is to warm, filter and humidify the air. As a thermostat it tempers the air until, even in zero weather, it is nearly blood temperature, when it reaches the lungs. The mucous membrane of the upper air tract secretes more than one quart of watery mucus each 24 hours. This is added to the inspired air and at the same time provides a protective film covering the epithelium. The nasal vibrissae and cilia of the mucous membrane filter and remove dust particles and bacteria from the air. In addition the secretion of the mucous membrane in all probability has inhibitory or slight bactericidal action as the introduction of bacteria into a normally functioning nose is soon followed by their disappearance.

The vascular system of the nose is most intimately connected through the sympathetic nervous system with remote parts of the body, particularly the skin and abdominal viscera. The greater reaction that some people show to thermal cutaneous or to visceral chemical stimuli may explain the greater susceptibility they have to catching colds.

Etiology. From the time of Hippocrates, weather conditions and meteorological changes have been considered responsible for epidemics of acute colds. It was thought that rapid changes from heat to cold, changes of the winds, chilling rains, as well as local application of cold to the body, in some mysterious manner brought the affection—hence the name "cold."

In the last two decades the theory of specific infection has been strongly supported by much clinical and experimental evidence, although no specific organism has been isolated. The nature of the inflammation, the clinical signs and symptoms, the well-known tendency of a cold to spread through a family or group closely associated as in schools or factories at once throws the common cold into that group of acute infections and contagious diseases caused by some specific organism.

Kruse in 1914 and Foster in 1917 were able to produce in several healthy individuals all the symptoms of the common cold by spraying their nasal cavities with a filtrate taken from the nose and throat of persons in the early stages of a cold. The filtrate was obtained by washing the nose and throat of subjects suffering from an acute cold, diluting it with normal salt solution and then passing it through a Berkfield N. filter. This would indicate that an invisible, filtrable virus was the inciting etiological factor in a common cold.

The above findings have been corroborated by other investigators, notably Dochez, Mills and Shibley, who were able successfully to transmit colds from human beings to the higher apes. However, Williams, Nevins and Gurley reported failure to infect or produce colds in forty-five volunteers with filtered washings taken from severe early colds and three typical influenza cases.

In the field of bacteriology the work of Kendal and co-workers of Northwestern University is attracting a great deal of attention and offers hope for a solution of the cold problem. He has demonstrated that various bacteria may assume different forms and sizes during their life cycle; at times visible, at others invisible, and may be passed through a Berkfield filter without losing their virulence. Dr. Kendal uses a special protein media called "K media" that differs from ordinary culture material in that it more nearly approaches normal living tissue. It seems reasonable to expect that in the near future, with better bacteriological technique, the specific germ of the common cold will be found.

The sinuses and cavities of the internal nose are normally sterile. However, in the nasal vestibule and post-nasal space are ever present pathological bacteria such as the various types of strep- and staphylococcus, pneumococcus, influenza bacillus and many others that probably become secondary invaders in the advent of a cold and may produce the more dangerous and disabling complications and sequelae.

In passing, one should not fail to mention two types of disturbed function of the upper air tract with symptoms of the common cold, which certainly are non-contagious. One is the allergic cold or coryza, which is due to a hypersensitiveness of the body tissues to certain substances, usually of a protein nature. The cause of the allergy may be plant pollens, animal epidermis, foods, bacterial proteins or certain other substances of a chemical nature such as orris root powder, talcum, as well as various drugs such as aspirin, quinine, ipecac and others.

Another type of coryza is brought about by disturbance of the endocrine glands, particularly a hypo-function of the thyroid and suprarenals in which the patient complains of periodic attacks of sneezing, lacrimation and nasal obstruction.

Predisposing and Contributing Causes. If we accept as tenable the filtrable virus theory of the common cold and the theory of secondary bacterial invaders as causing the real damage and danger to the patient, then the other factors so intimately bound up with the process of "catching a cold" such as weather changes, exposure to cold, climate, as well as local and general physical conditions, should be classed as predisposing and contributory causes.

An attack of cold confers a very transient immunity on the patient, certainly not longer in most persons than a few weeks. However, some persons possess a variable degree of immunity as they seldom or never have colds.

Colds occur most frequently during winter and spring months. Observation has shown that rapid changes in outdoor temperatures, especially if associated with excessive precipitation, is apt to be followed by an increase in upper respiratory tract diseases.

In regard to climate we are often asked, "Where shall we go to avoid having colds?" The conclusion of many investigators, notably Barnhill of Indiana University, Barrows of Stanford, Hunington of Yale and others, is that there is no perfect climate. Barrows' researches related to the relative frequency of colds among students in widely separated universities. At Stanford, where the climate is mild and indeed rather ideal, practically the same number of students per hundred investigated suffered from acute colds as suffered from the same affection at Harvard where the climate is comparatively rigorous.

Hunington of Yale bases his conclusion not alone on his own extensive researches but also upon the researches of many others, and concludes that the most healthful climate is to be found about New England, the St. Lawrence River country, and the region around the Great Lakes. This is in variance with our usually accepted idea that the nearly perfect climate free of colds is to be had by journeying to Florida, southern Texas, Arizona or southern California. Barnhill concludes that on general principles a mild climate free from sudden and marked changes in temperature from midday to midnight with plenty of sunlight, all of which permits of a maximum of pleasurable, comfortable outdoor exercise, is the best place to live in order to avoid or clear up affections of the upper respiratory tract.

Chilling of the body surfaces by cold, either with or without overheating, is unquestionably a predis-

posing factor in the catching of a cold. Mudd, Grant and Goldman, in a series of experiments on young healthy persons, showed that exposure of the body surfaces to wet chilling draughts cause an immediate vaso-constriction and ischemia of the mucous membrane of the nasal cavity, post-nasal space, oropharynx, palate and tonsils with a marked fall of the mucous membrane temperature, which in some cases amounted to as much as six degrees. They also showed that the fall in temperature persisted for fifteen or twenty minutes. This ischemia with a drop in temperature of the epithelium may create a temporary weakening or loss of resistance of the cells with resultant invasion of the tissue by pathogenic bacteria that are ever present.

The presence of irritating foreign substances in the air such as dust and smoke, irritating vapors such as the sulphurous acid gas carried in coal smoke, tend to devitalize the nasal epithelium, stop the ciliary action and render it vulnerable to infection.

Present tendencies to overheat homes, which reduces the humidity to less than one-half of what it should be, dries out the respiratory membrane and interferes with the normal protective function of the nose. If homes were kept at one temperature, preferably not over 70 to 72 degrees F., with sufficient moisture and proper ventilation to keep the air moving, the number of colds would be materially lessened.

Instability of the vaso-motor system in certain individuals, usually of the so-called neurotic type, predisposes to the taking of colds. This type of person usually complains of cold hands and feet, and is very susceptible to sudden changes in temperature. When the air is cold, they readily chill; when they enter an overheated room, they break into profuse perspiration. These individuals can often be hardened against colds by a process of daily cold showers or cold applications to face, neck and arms, and the wearing of clothing of the proper weight and texture.

Local conditions within the nasal cavities that might be termed "bad anatomy," which interfere with the normal function of the nose, predispose to colds. These include nasal obstruction due to deflected or thickened nasal septum, spurs, enlarged turbinates, hypertrophy of the posterior tips of the lower turbinates, nasal polyps, as well as enlarged adenoids. Foci of infection in the tonsils or within the nasal sinuses, particularly the ethmoids and antra, are frequently responsible for the repeated taking of colds in both children and adults. One or more members of the family may be cold carriers and repeatedly spread it to others. It is a well-known fact that when an acute cold starts in one member of a family or group closely associated, it nearly always spreads to the rest.

There are many general conditions that may be considered contributing causes in that they predispose to the taking of colds. Lowered body resistance due to chronic foci of infection or debilitating diseases, diet deficiency in vitamins A and D, according to Wollach and Howe of Harvard, lead to an atrophy of the epithelium of the upper respiratory tract, which is replaced by a keratinized epithelium which is less resistive to bacteria. Overloading the digestive tract with rich food, particularly carbohydrates and proteins that cannot be metabolized, result in a disturbance in quality and quantity of the blood supplied to the respiratory mucosa. Fatigue, exhaustion, insufficient food, disturbed nervous systems are all internal causative factors that lower the natural immunity and thus predispose to the catching of colds.

Of late the relationship of gastro-intestinal conditions as predisposing to upper respiratory infections has been noted, particularly faulty digestion with the formation of abnormal amounts of split-protein products in the intestinal tract such as histamine and certain other amines which cause a vaso-constriction of the vessels of the abdominal viscera with a compensatory dilation and congestion of the nasal mucosa. This venous stasis prepares a fertile soil for bacterial invasion.

Again we find physicians, notably Cheney of Chicago, concluding after extensive laboratory studies that there "is a decrease in the bicarbonates or reserve alkaline bases contained in the blood plasma and the tissues, notably in that of the sodium and calcium salts." He believes that a cold is a "mild acidosis" and that "thorough alkalinization will always abort and cure a cold." No doubt a condition of mild acidosis does exist which calls for the administration of additional alkalies of sodium and calcium. However, I am sure that most physicians are of the opinion that this condition follows the disease and is therefore caused by it.

Pathology. The pathology of an acute cold has been studied by different investigators. Hilding removed bits of mucosa at different stages of the disease and reported the microscopic appearance. The reaction in the early or dry stage is characterized by swelling and increased hyperemia of the mucosa. In a day or two there is an abundant flow of thin mucus and cast-off mucous cells are poured out on the surface. There is nasal stuffiness caused by swelling of the nasal epithelium and engorgement of the vessels of the tunica propria.

The leucocytes are greatly increased in the tissues and are extruded until finally after three to six days the exudate becomes muco-purulent. This is the so-called third stage of a cold. If the reaction is exceedingly severe, there is complete breaking down of the epithelium, which is cast off. The process may involve the basement membrane and submucosa. If there is much deposit of fibrin on the surface, a fibrinous membrane is formed, and on the addition of purulent exudate thick crusts are formed. Further destruction produces

ulceration with numerous bleeding points and formation of bloody crusts. The last stage is the stage of repair and begins as soon as the reaction to the infection ceases. If the infection has been mild there is complete restoration of the respiratory epithelium, including the cilia. In repeated or long continued infections with complete destruction of the mucosa extending into the submucosa, restoration is made at least partially by the proliferation of connective tissue cells. Severe and repeated head colds will in such cases greatly reduce the physiologic function of the nose.

General Management of a Cold. An uncomplicated cold runs its course in from three to seven days. Treatment serves to make the patient more comfortable and to prevent complications and sequelae, and in this way shortens its course.

The patient, if possible, should be isolated and in bed two or three days in a well ventilated room. A mild laxative to assure elimination should be given and the forcing of fluids, especially fruit juices, is highly desirable. Alkalinizing the system and the administration of calcium in some form theoretically is indicated. The use of omnadin or some other nonspecific therapy given daily intramuscularly has been highly recommended by Mithoefer and others. It is especially effective in early naso-pharyngitis and in preventing the complications of the common cold. Massage properly given to the nose, face and neck seems to relieve congestion in the upper air passages. To relieve headache, muscular pain and to keep the patient comfortable aspirin or some other analgesic drug is useful. Cold tablets containing some form of belladonna or opium are effective in relieving excessive lacrimation and serous nasal discharge. The diet should be considerably reduced.

Local Treatment. In the early stage of a cold local treatment should be directed toward relieving the nasal stenosis. Of the various drugs used to shrink the nasal mucosa ephedrine in some form is the most desirable, as it brings about prompt and well-sustained tissue shrinkage with improved respiratory ventilation and speeding up of the drainage currents. Stark and others have shown that ephedrine is well tolerated by the tissues and seems to produce little or no injury to the nasal mucosa when applied at regular intervals for comparatively long periods of time.

The use of antiseptics in nasal therapy has proven rather disappointing, particularly in the early stages, as most of these drugs irritate and tend to increase the congestion and swelling of the mucosa. It is hardly likely that any of the agents reach the bacteria lying in the deeper layer of cells.

In the later stage—the muco-purulent stage—shrinking the nasal mucosa thoroughly with a one per cent cocaine-ephedrine solution in normal salt to be followed by fifteen or twenty per cent argyrol or neo-silvol solution, either as the Dowling packs or sprayed into the nose, left in place for several minutes, then douched out with a warm normal saline solution, seems to produce good results. Care must be exercised to prevent entrance of the saline solution into the eustachian tubes in order to avoid middle ear infection. The naso-pharynx should be thoroughly swabbed with a twenty or twenty-five per cent argyrol solution. For home use some form of ephedrine, either aqueous or in oil, is very satisfactory and should be used often enough to keep the nose freely open. Vaccines are of no benefit during the active stages of a cold.

Prevention. There are many aids but no sure way to prevent the acute cold. After all, the thing that helps one person may fail to help or may make another worse. As a general rule an attempt should be made to build up the general health and resistance of the individual. The use of ultraviolet radiation, better hygienic conditions in the home, school or place of work, and vitamin replacement by proper diet and medication is essential. All foci of infection in the teeth, sinuses and tonsils should be removed. The wearing of clothing of the proper weight and texture must receive consideration. Hardening the individual by the cold shower method helps some individuals. Others do not react properly and are made worse by the treatment. Restoration of normal nasal physiology by removing, in so far as possible, all bad anatomy within the nose is necessary. Vaccines, either the polyvalent stock vaccines or better, the newer type of selective vaccines, undoubtedly are a help in preventing head colds in a great many individuals. Removing of the susceptible person during the months of bad weather to a less rigorous climate where there is more sunlight and out-of-doors living certainly is desirable.

With the impetus given laboratory workers by Kendal and others through their recent studies of bacteria, it is not rash to expect in the near future, discovery of the specific cause of the common cold, after which will come a better understanding of the whole pathological process and more rational methods of treating and preventing the most prevalent of all diseases.

SYMPOSIUM: COMMON COLD

VIEWPOINT OF THE GENERAL PRACTITIONER

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We all recognize that isolated human communities should offer ideal conditions for the study of epidemic characteristics of disease. Thus, when an epidemic occurred it would be possible to determine the exact date of introduction of infection into the community, to fix the incubation period of the disease, and to trace the epidemic throughout its

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course in the community. Each individual contact would be known, contacts with the outside world would be excluded, and environmental factors would be determined with relative accuracy.

With this in view, Smille and his coworkers of the Rockefeller Institute for Medical Research, made careful studies of the common cold in three isolated communities. These communities were located in the interior of Labrador, southern Alabama, and St. John, Virgin Islands. In each of these locations they were able to minimize extraneous factors, life was simple, outside contacts infrequent, and environmental factors more accurately determinable and controllable.

A few of the conclusions reached by these studies have a pertinent and interesting bearing on our subject. Statistics reveal that there is an average of over two colds per person per year in the temperate zone. Studies also show a seasonal incidence of colds with a peak in the fall, a decline, and a second and higher peak in the late winter.

The most careful bacteriological studies were carried out by the investigators at each of the communities, both upon normal individuals and those infected with colds. In general, the same types of organisms were found in the naso-pharynx of persons living in isolated communities in the tropics, in the temperate zone, and in the Arctic zone. There was no significant variation between adults and children or between sexes. The studies seem to indicate that the normal basic flora, not related to acute respiratory diseases, include Gram-negative diplococci, the *viridans* group of streptococci, and the diptheroids. The most striking feature of the bacteriological data is the constancy of the findings. They were unable to show any significant variation in the naso-pharyngeal flora in persons with colds and in normal individuals. The colds, it is true, were more prevalent in the winter months, and certain organisms were more prevalent in winter than in summer, but the increase in these organisms occurred in normal throats as well as in those of persons with colds.

Another fact was observed, however; namely, that pneumococci did seem to have some pathological significance, and in an epidemic in Labrador which was studied an increase in the influenza bacillus was noted. They point out in this connection that the increase in these two organisms did not occur during the initiatory stages of the disease, but were most prevalent from the fourth to the seventh day of the infection. These observations suggest that colds in all three areas were initiated by some factor which is not as yet discovered, and also indicate that colds may run a mild course without any modification of the customary naso-pharyngeal flora. It seems probable, however, that the severe secondary symptoms associated with colds are produced by organisms with which we are perfectly familiar, namely, pneumococci and Pfeiffer's bacilli.

A common belief, and one already referred to by Dr. Lingeman, is that rapid cooling of the body surface, such as would occur if one were caught in a night rain when wind is blowing, or if one worked hard and then cooled his perspiring body quickly in the wind, would certainly result in a cold. These studies gave no evidence as to whether or not this factor was of importance in the incidence of colds.

Another question which these studies attempted to answer is, "What is the inciting etiological factor of colds, environmental or a specific infectious agent?" Evidence is produced to support each of these theories. Remarkable opportunity was furnished in all three of the locations to observe the progress of an acute infection brought into the isolated community. The case of an infection brought into the isolated community of the Virgin Islands by a sailor and spread subsequently throughout the island gives excellent evidence that the outbreak was spread through direct contact of well persons with an infected individual, the incubation period being two or three days in each case.

On the other hand, evidence is very strong that environmental factors play a definite part in the incidence of colds. In each study epidemics of colds followed a drop in temperature. Furthermore, the seasonal curve of incidence of colds in the tropics is very similar to the seasonal curve in the temperate zone. However, if the disease had been initiated solely by environmental factors one would have expected that all individuals in all communities would have developed the disease simultaneously. Since the disease spread in concentric waves from a central point, with definite periods of time intervening, they were forced to conclude that the colds had a common source, probably infectious in nature, spread by direct contact and with a definite incubation period, although it seems most probable that environmental factors, such as relatively low temperatures, predispose to such infection.

The term "cold" is undoubtedly a misnomer, but it has become so ingrained in the minds of both the profession and laity that any attempt to change it is useless. The term probably originated from the association of cold, wet weather and drafts, as well as from chilling, which so often accompanies the onset.

The great majority of all patients with colds, especially in the smaller communities, consult the general practitioner first. It is only after the development of some of the complications already referred to that we seek advice and treatment from the specialist. It should be the province of the general practitioner to prevent these complications, so far as possible, by judicious handling of these colds in the early stage. Knowing the contagiousness of the infection, our first thought should be the isolation of the patient for the welfare of others. Especially is this important in school

children, where contact with thirty or forty others in a room surely means many more cases in the next few days.

Handkerchiefs should be replaced by paper napkins or gauze which can be burned after use. Of course, all sneezing and coughing should be protected. Individual dishes, silver, etc., should be insisted upon. The sleeping room should have an abundance of fresh air, and the temperature should be only slightly higher than the outer air.

Our next effort should be to prevent the complications which may prove serious or even fatal. If our patients with acute colds would only follow our advice and go to bed for a few days, how much better it would be for all. To convince a busy, otherwise vigorous man, however, that it is necessary to do so is many times an impossibility. It is only when the disease has reached the stage of complications that the patient begins to think himself sick enough to consider staying at home and possibly going to bed. Of course, if fever is present, we must insist upon the patient going to bed immediately.

If it is possible to secure the co-operation of the patient to the above extent, very little medication will be necessary. I was especially glad to hear Dr. Lingeman say not to meddle with the nasal mucosa in the early stage of an acute cold. Anyone who has experienced such treatment surely will testify to its extreme pain and lack of benefit. The treatment could almost be reduced to the old adage of keeping the head cool, the feet warm and the bowels open. However, the hot pack, accompanied by a mustard foot bath and hot lemonade, is of benefit. Belladonna and its derivatives are of doubtful value and really add to the discomfort of the patient by producing a dry nasal and oral mucous membrane.

The practical results of these simple measures will be the rapid recovery of the patient, the probable elimination of all complications and the positive reduction of the number of colds in the family, school or community.

The importance of cold in the head in public health and sanitation is an indirect one. The condition itself is so trifling that vigorous individuals usually do not permit the disease to hamper their daily pursuits, and in consequence promiscuous association continues without precautions. As a result colds go through families, schools, businesses and reach the proportion of small epidemics.

From a sanitary point of view the consequences are serious. As has been pointed out, the predisposing effects of a cold to graver infections of the upper respiratory tract are considerable and a certain percentage of individuals with neglected colds contract the various forms of bronchitis, laryngitis, and bronchopneumonia. Even more serious than this is the fact that during the course of the condition the indiscriminate scattering of saliva, nasal and bronchial mucus occurs to an increased degree. Sneezing, coughing and spitting freely disseminate the mouth and throat organisms of individuals and a general interchange of mouth and throat bacteria occurs. If this could be made clear to the people they would undoubtedly be so disgusted that a marked improvement in personal hygiene would be seen at once.

Colds present one of the most difficult and serious factors in the sanitary control of diseases of the respiratory tract because of the vicious circle of carriers and cases which follow in their train. Control is a discouraging problem. Prevention depends not so much upon the enforcement of any specific precautions as it does upon the recognition of the seriousness of the secondary consequences to the individual and to the community. Nothing of any moment will be accomplished in the control of colds until education of the public has sufficiently progressed to lead to greater personal cleanliness and hygiene; to the realization that a person with a cold should be temporarily segregated; that sneezing, coughing and spitting in public places is a source of great danger; that people with colds should not kiss others, should use disposable tissue for handkerchiefs, and should avoid exposing others by refraining from going to places of public amusement, etc., until the excretory stage of the malady has subsided.

It is futile to talk about the treatment of colds or even split hairs as to causative organism. That will not reduce the incidence of the disease. The big, important problem that we must face is the control of the spread of the infection to others. Until the public generally develops a feeling about colds akin to the attitude we have developed about pure water, adequate sewage disposal and other modern ideas of sanitation, it will be hard to make any impression on the condition as we now have it. No one questions the absolute necessity of a pure water supply, and the expense is a secondary consideration. So, also, even the most uninformed in matters of sanitation realize the importance of proper sewage disposal. This attitude toward sanitation and hygiene have been won only by centuries of education, for it is only a step backward to the middle ages when such precautions would have been considered utterly unnecessary even by the most enlightened of that day. It may seem just as radical to some to propose strict isolation or even quarantine for those persons suffering from a common cold. Lack of education in the simple hygiene of everyday life leads, above all else, to carelessness of the rights of others in regard to infection. Honorable citizens who would abhor to contaminate a city water supply or interfere with the proper disposal of sewage have no compunction about coughing and sneezing in each other's faces or sending their children to school with acute colds.

The schools themselves are not a little to blame in this connection since they have made such a fetish of attendance records with their gold stars and banners. The parents of the child, absent from school with a cold, should be awarded the

gold star for their consideration of other children.

By constantly preaching the gospel of personal hygiene, and by the realization on the part of the public of its responsibility for the great spread of illness and suffering by lack of thought and care, the time will come when the man who would expose others to his own infection will be looked down upon as a social renegade. When the public becomes "cold conscious," as the popular expression has it, then it will rise up and demand these reforms. It should be our job to further this end not only by our counsel but by our personal example.

DISCUSSION

W. H. TERRELL, M. D. (Pittsboro): I am a general practitioner, giving some special attention to the diseases of the nose and throat. If the acute or common cold could be eliminated, the doctors, and even the surgeons, would have less to do. One thing I want to mention is sudden change of temperature as a cause of colds. I have been a school physician in a school where there are over 300 enrolled in the township in which I live, and I have noticed for the last two or three winters that whenever there is a sudden change of weather from warm to cold, a large number of the children will be coughing and sneezing the next day or two. It would be a big job to keep these children at home when they want to go to school, and are not feeling badly enough to stay at home, so they go to school and convey the disease to others until a large percentage of the pupils have colds, some develop ear troubles and perhaps have to be operated for mastoid involvement.

Until we find the specific cause we cannot do much in the way of treatment of the common cold, and I think we will not be able to cut down colds in this country very much until the people learn that if a child has a common cold they are justified in keeping him at home. It is up to the profession to instruct the parents to keep their children at home and to stay at home themselves when they have a cold.

JOHN F. BARNHILL, M. D. (Miami Beach, Fla.): The common cold is one of the most important questions in medicine, and I wish therefore to commend the excellent papers we have just heard.

No one knows exactly what causes cold. Some of the greatest efforts of scientists have been devoted to this subject because it is a great economic as well as an essential health problem. My own feeling is that the common cold is an infection—nobody knows what. I believe it is a filtrable virus. Many persons who argue against that will say that in the desert people have colds—persons who are there for months at a time, wholly isolated from infection, catch cold. How could that be? It could easily happen—they once were infected, now carry infection, and reinfect themselves. That particular phase of the question has not been given enough attention.

Everyone, some time in his life, has suffered from a common cold. This may have left a focal infection which the individual may carry for a long time. Then, infection being the cause, the predisposing cause is a change in temperature. There is no climate that I know anything about that does not have changes of temperature sufficient to bring about colds. One of the papers just read mentioned that even in the tropics such changes occur. They occur everywhere, and if the individual who carries a focal infection anywhere in his body is not properly protected he suffers from acute rhinitis.

A word concerning treatment. We never can treat a cold properly, of course, until we know the specific cause. It has been alleged that we have not made much advance in one hundred years, and I think that is true. On looking back one hundred years in medical literature to see what people then did for cold we find they did about what we do today—kept the patient indoors, the feet in hot water with mustard, gave an old-fashioned Dover's powder, sweat him, and in these ways tranquilized the nervous system and helped materially.

Some of the arguments made here today should be remembered. Someone said that atropine is not serviceable. I think that is true. Nature, unhindered, pours out a great quantity of secretion, and we should take a hint from that—we should not stop the secretion with atropine, for to do so probably prolongs the affection. On the same ground I am not certain but what we could say that putting the feet in hot water with mustard does harm, for we know that in order to kill the infection locally present there must be a great increase of blood to the part where the infection has taken place. If we drive the blood from the nose to the feet by a hot mustard bath, is it proper? It probably is not. Another helpful thing the old-time doctor did was to give the patient all the water he could drink—eliminating through the skin the poison in the patient's system. If he likes lemonade, all right, but give him fluids. If you give the fluids hot you get double help—elimination from the water and sweating from the heat. Those suffering from common colds should drink all the water they can.

A word about opium. Opium given in the beginning of a cold is the best drug we have. I cannot explain fully what it does, but only know its value. One-sixteenth of a grain hypodermically is, I believe, our best drug if given at the beginning on recognition of the first symptom.

I wish to emphasize what Dr. Reed mentioned—the spread of these infections by sneezing, coughing and promiscuous intermingling with those who have colds. Sneezing and coughing in crowded, illy-ventilated rooms are certain means of spreading colds. The best known way to prevent colds is to keep the patient away from other people. Any-

body can for one cent buy an individual drinking cup and can thus easily and certainly prevent infection from such source, but it is difficult to prevent spreading infection through the air. There is no individual respiratory apparatus which purifies the air. One who sneezes pollutes the air all about him. There is no way to prevent it. I do not know how you are going to stop it. Someone said that until we can create the feeling on the part of the people that it is dangerous to sneeze in crowded places, little progress will be made. Sufferers from colds sneeze in crowded places and everyone laughs about it. They condone it instead of running away. As long as the public condones that sort of thing and treats it as a joke, danger from colds lurks in every crowd. If patients who have bad colds go to a theatre sneezing the theatre will be full of infection, and all present may be contaminated.

C. N. HOWARD, M. D. (Warsaw): I would be glad if, in closing the discussion, the essayists would state what they think in regard to alkalinization. In recent years thorough alkalinization with bicarbonate of soda has appealed to me.

JOHN W. CARMACK, M. D. (Indianapolis): Most of the investigative work in the past several years has rightly been an attempt to find the exact cause of colds; also toward building up immunity to colds along the line of giving the various vitamins, proper food, immunizing agents, etc. All these things are fundamental and proper, but it seems to me we have lost sight, to a considerable extent, of the difference in the virulence of organisms, and the fact that these are transmitted from one individual to another. Unless we keep these things constantly in mind we accomplish very little for the patient who has a cold.

In regard to local treatment: The cilia of the nose are difficult to destroy under certain conditions, they being the chief cleansing mechanism of the nasal mucosa. Dr. Mosher's laboratory has demonstrated that cilia may live for something like fourteen hours after the death of the individual. They last for a long time and their action continues. However, certain things that are of a toxic nature immediately stop their action. The first is bacterial toxin, and the second drug toxin. This is the point I wish to make, that by local applications to the nasal mucosa the action of their cilia may be affected. It has been demonstrated very definitely that the application of argyrol in the way of packs in the nasal passages will stop the action of the cilia in a few minutes. Any silver protein will produce the same effect if it is applied for any considerable period. By the application of so-called antiseptics to the nose we may do harm instead of good.

Ephedrine, one of our most valuable drugs, if overused, exhausts the cilia and vascular mechanism, producing a stagnation on the surface and vascular congestion. We cannot destroy the bacterial flora in a nose infection without harming the nasal mucosa. Local treatment must be directed toward supporting the normal physiology of the nose.

DR. E. L. LINGEMAN (closing): In answer to the question about the alkalinization of the patient, I think that is desirable, because it has been shown by laboratory tests that there is a reduction in the basic alkalies, sodium or calcium.

STATE MEDICINE

THOMAS F. O'MARA
TERRE HAUTE

I have the conviction that after all the study and investigation devoted to medical economics, the major premise of state medicine has been entirely overlooked.

The original thesis of Karl Marx was this: The ownership in common of the means of production and distribution. The thesis of the proponents of state medicine, under whatever guise, or however careful the concealment, is the ownership in common of the services of the physician. State medicine is, therefore, nothing more than an extension of the fundamental principle of communal ownership so as to touch directly the professional services of the physician.

Does the profession intend to accept this thesis as a matter of principle? Unless the profession is willing to swallow the socialistic concept, then the profession must determine what is the proper reaction to the various schemes of governmental interference with the practice of medicine, not from the standpoint of what may appear to be good or expedient at the time, but from the standpoint of the principle involved.

There has been much illuminating discussion of the resistance proposed to the recently inaugurated movement of opening the various federal hospitals to the treatment of nonservice connected disabilities. Fortunately, this is one subject upon which the profession has united with singular unanimity. I believe that is true because perhaps unconsciously the profession as a whole has felt that here was a clear case of the overextension of the governmental activities. Here is an illustration of the socialistic nature of the whole concept of state medicine.

The modern state has become overshadowed with the self-seeking of interested groups. Blocs without name and number have attempted to obtain and in large measure have succeeded in securing governmental support and untold millions from the public treasury. Scarcely a one of these propositions has not been socialistic.

The medical profession as such is, of course, interested in the matter of governmental appropriations generally only in the sense that anybody else

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is interested therein. When the appropriation, however, is to secure governmental control or governmental operation in the field of what should be the practice of medicine proper, then the profession, on account of its peculiar knowledge and interest in the subject, should become the representative of the thinking public in planning and directing the necessary opposition to such movements.

You are to be congratulated and commended on the real accomplishment of correcting, in at least a degree, the views of the American Legion on the subject of the further extension of the operations of government hospitals. The representatives of the committee who have been interviewing the officers of the American Legion have done this largely in their own name and in the name of the profession.

In discussing this matter at Indianapolis before the county medical secretaries of Indiana last June, I pointed out what I think is essentially true in any discussion of the medical profession in relation to governmental subjects in which they may have some interest, and that is that the medical profession can exert but a partial leadership without the help of allies. How is the medical profession in America, in point of numbers entirely incomparable to the members of the American Legion or any other large group of people, to conduct a successful opposition? Politically, the comparison is hopeless. Allies are what you need. Allies you must have, and allies you can procure. These allies are of two kinds; I characterize them spiritual allies and practical allies. The spiritual allies are those who, from their immediate, kindred instinct or as a matter of principle, concur in your opposition to state medicine. The practical allies are those who from that major consideration of life, direct financial interest, will support that opposition.

There are in this country today substantially 150,000 of the legal profession who appreciate instinctively the intimate, confidential relation that exists and must continue to exist between the physician and his patient, and who would resist any attempt on the part of the government to break down the sanctity of that relationship. These 150,000 lawyers, men whom you have never taken the trouble to acquaint with your difficulties and the dangers of state medicine, will see eye to eye with you as soon as they are acquainted with your views. In addition, there are many of the other professions, particularly the clergy, who believe in personal independence, who believe in the dignity of human nature which is destroyed by the mechanism of state medicine. These spiritual allies are available today and their help can be had almost for the asking. The price of their enlistment is the negligible cost of the necessary publicity.

Another source of practical aid which the rapidly changing conditions have emphasized, even since last June, is the organization of taxpayers' associations in an effort to resist the mounting cost of government. As a matter of comparison, let me ask you this question: As ably as Dr. Crockett and Dr. Wright could put their arguments as representatives of the Medical Association, how much more potently could a taxpayers' body put this matter to the members of Congress? Compared to the now rapidly swelling numbers of the various taxpayers' groups, the numbers of the American Legion dwindle into insignificance. Politically considered, the voice of the taxpayer of this country is far more potent than the voice of any interested group, and that voice soon can be summoned to your aid.

Comprehensively stated, the solution of the problem of state medicine will come through the enlistment of these spiritual allies, through publicity and propaganda; the enlistment of the practical allies through the participation in retrenchment-movements by the individual in your profession and the profession's only organs for self-expression —namely, the various medical societies.

The immeasurable weight of eternal right is with the profession in its struggle. The service of the sick, in its finer essence, will be impaired by the attempt to care for them through socialistic methods. Socialism is nothing more than an attempt to put an economic straight-jacket upon the physician—to rob him by stealth of the great gift of healing and to dispense that gift through breaking down the individuality and self-respect of the physician. This constitutes an interference with the individual liberty of man. It is, therefore, dangerous and destructive. This must be recognized as the major premise in any approach to a consideration of any public movement looking to the centralization of health and medical relief. If it operates to interfere with the freedom of the individual physician, it is fundamentally wrong.

The second consequence of the communal ownership of medical service is that it operates to break down real co-operation. That co-operation must exist between the members of the profession itself. It must be always kept in mind that the right to associate with others is an indispensable part of individual liberty. And this is true both from the standpoint of those who employ physicians and of the physicians who are being employed.

This brings me to a consideration of the subject which Dr. Leland discussed this afternoon—namely, contract medicine. Except to the extent that it has been consciously exploited for pecuniary profit, contract medicine is largely the outcome of blind and unconscious efforts at co-operation to secure a reduction of medical cost. In itself, this co-operation is not wrong and perhaps will become increasingly necessary. The wrong comes in when it is exploited by unsound or designing schemes or the wrong lies in the methods of its operation. When wrongly conceived or wrongly administered,

contract medicine takes advantage of economic conditions to constrain the services of the physician and to restrict his freedom and induce him to depart from the ethics of his profession, and ultimately causes impaired medical service to be rendered to the sufferer and breaks down the personal relationship which should exist between the patient and the physician.

I have been much interested in an able article by Dr. Leland, evidently carefully based on a great deal of investigation. I am pleased to read, on page 18 of this pamphlet, entitled "Contract Practice," that he has formulated some of the points with reference to which contract medicine must be judged. He says: "Each case must be judged on its own merits when all the facts pertinent thereto are known. From a certain point of view we may . . . determine whether a contract is unfair or unethical. This may be stated as follows: First, if the compensation received is inadequate, based on the usual fees paid in the community; second, if the compensation is so low, etc.; third, if there is underbidding by the physician in order to secure the contract; fourth, if a reasonable fee is denied in an attempt to keep other physicians out of the practice; fifth, if there was selection (solicitation) of patients, directly or indirectly."

With these remarks of Dr. Leland in mind, let us assume in a proper case the propriety of contract medicine. Let us assume that under the operation of economic laws contract medicine will flourish and reach a higher degree of development. Nevertheless, with Dr. Leland's analysis before us, it is susceptible clearly of great abuse. If that abuse develops, it will operate to undermine the profession and victimize the public.

The abuse of contract medicine, however, seems to me to arise in part from the failure of the medical profession to recognize that in the ordinary course of things there will be a constant effort by the needy or the industrially disabled portion of the public to avail themselves of cooperative funds, such as are afforded by compensation, insurance and relief associations. Such co-operation, as has been pointed out, is in itself no evil. It may be, if properly controlled, commendable.

These co-operative schemes which generate contract medicine are in effect nothing but collective bargaining on the part of those who are to be medically served, either through conscious or unconscious agencies. The evil is in that the profession has not been organized on its side. The collective bargaining and control has been all on the side of those being served. The profession itself has not done collective bargaining, and it has not organized itself in any effective manner to discipline the individual members of the profession who engage in contract practice. If contract medicine is controlled from without, the control will be haphazard, unintelligent, intermittent and perhaps socialistic. It may be doubted very much if the evils which Dr. Leland has enumerated are not in their nature susceptible to control only from within the profession itself.

This necessitates effective self-government on the part of the profession whereby the profession can control contract medicine. There is a vast difference between the freedom of the individual physician to contract with the individual patient and the freedom of the individual physician to contract with unknown patients en masse, through a commercial or corporate agent. The first is simply a matter of individual liberty subject only to the general rules of ethics under proper medical standards, and can be in a great measure left alone with safety; but the second requires the professional control of the situation or else all co-operative or contract medicine will be left unregulated with consequent deterioration of the profession and victimization of the public or we will have unintelligent, unwieldy and perhaps socialistic state control. A page may be taken from the book of the lawyer's experience in this matter. We have had a great deal of purely corporate practice of law in this country in the last decade, but we are recovering from it. That recovery is due to the organized effort of the profession as such, and in this direction lies, I believe, the solution of all problems of contract medicine.

The physicians of this country, at this time, in their struggle against governmental control and the evils of corporate and contract practice, stand on the firing line of individualism where the battle is fiercest. As a member of a brother profession, a profession which, as I have indicated, has had and has similar problems, I wish you success in your efforts to resist state medicine because your cause is not alone the cause of your profession, but the cause of individualism at all times and in all places.

PRELIMINARY REPORT ON TRANSILLUMINOGRAPHY

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INDIANAPOLIS

The transilluminogram, as its name would indicate, is simply a picture showing what the physician sees when he transilluminates a sinus.

In the past the making of such pictures has been impossible due to the lack of any film sensitive enough to red, which is, of course, the predominant color seen in transillumination.

Since the advent of Eastman's supersensitive panchromatic film, I have taken a number of transilluminograms which show detail with surprising clearness, even to the extent of showing light transmitted through the pupil.

Several different transilluminators were employed, but the Freer transilluminator, which uses a 110-volt bulb, was the only one which gave sufficient light to make a satisfactory picture.

After numerous trials, it was found that the best results were obtained while using an Eastman clinical camera at a distance of 30 inches with the diaphragm set at F 7.7.

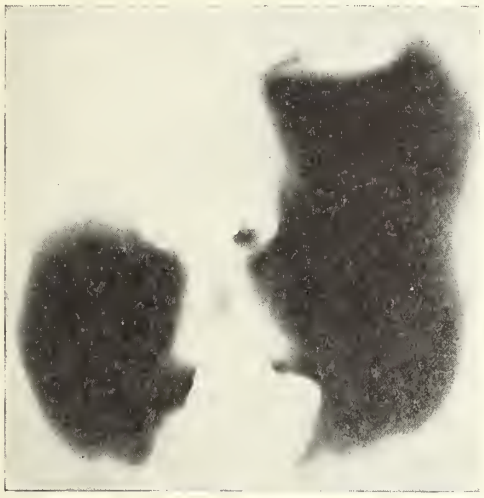


Fig. 1. Transilluminogram of a patient with acute maxillary sinusitis.

The patient was seated with his head against a solid support, and he was instructed to hold the transilluminator in his mouth, using his hand as a shield to prevent the escape of any light about the base of the bulb. He was further instructed to keep his eyes wide open, and to gaze directly at the camera without moving. All lights were then extinguished, and the room made perfectly dark. The camera was set for a time exposure, the transilluminator was turned on, and the camera shutter was opened for 90 to 120 seconds.

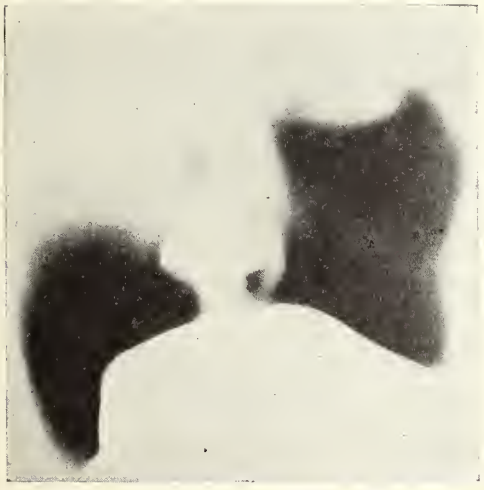


Fig. 2. Transilluminogram of the same patient taken four days later.

In some cases where the patient's mouth was quite small the bulb was used without any shield, and the patient was instructed to grunt without moving his lips if the bulb became uncomfortably warm; whereupon, the light was turned off for 10 or 15 seconds and due allowance was made by adding this time at the end.

Only maxillary transilluminograms have been made up to the present time. However, this method should be equally effective in the case of frontal sinuses. Transilluminography may be of value to the profession due to the fact that it gives the physician a permanent record, and it enables him to compare the results of transillumination in any patient from time to time without having to trust entirely to his memory. The transilluminogram is only intended to supplement and not in any way displace the x-ray.

OFFICE GYNECOLOGY

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CHICAGO

The practice of gynecology falls into three geographic departments—home, office, and hospital. The bulk of it is office practice, especially for the woman physician and surgeon. This has so many aspects that it is interesting to consider some of them in some detail. It is rather generally assumed that women have more aptitude for this than the brilliant male surgical gynecologist.

Menstrualpathies. Among the most frequent conditions seen are menstrual disturbances. These may be observed in the adolescent girl, through the twenties and thirties, and on to the woman in her menopause.

The mechanism of menstruation is not yet fully understood, but that it is in some way dependent on ovulation and the glands of internal secretion has been well established. As soon as we know exactly the rôle of these different glands, therapy will be more exact. At present we give glandular products on more or less an empiric basis. Our frequent failure to get the expected results is due to the incorrect interpretation of the mechanism involved.

It has been shown in sections of the ovary and endometrium, in all the various stages, that the new ovarian follicle begins to ripen at the close of each menstrual period. With follicular ripening there is a corresponding building up of the endometrium which becomes ready to receive the ovum if fertilized. The follicle ruptures about the 12th to the 17th day in the menstrual cycle. If implantation fails to take place, the ovum dies and passes off with the expulsion of the mucous membrane. The corpus luteum forms some time after the rupture and death of the ovum and causes the cessation of menses. If fertilization does take place, it is called the corpus luteum of pregnancy. Gynecologists believe that bleeding during pregnancy and some early miscarriages are due to interference with the corpus luteum formation.

Different results with ovarian extracts depend on the interpretation of the symptoms, which, in

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turn, are dependent upon when in the ovarian cycle the trouble occurs. Middle pains and middle bleedings are probably caused by difficulty or disturbance in the rupture of the ovarian follicle.

If the follicles form and rupture too frequently, the periods occur too frequently. If the corpus luteum does not form, menstruation starts but does not stop.

Any disease or condition or psychic state which affects the glands of internal secretion in general may disturb the ovarian function and therefore may give rise to menstrual disturbances.

Menstruation is not affected by inflammatory conditions in the pelvis unless the ovary is primarily or secondarily affected, i.e., unless there is an oophoritis. When the ovaries are inflamed there may be an interference with the normal ovarian cycle, which inflammation may cause the same symptoms as a non-inflammatory dysfunction.

The amenorrheas, menorrhagias, and the metrorrhagias may be due to one or more of several causes, but usually are due to ovarian dysfunction. Dysmenorrhea may be due to ovarian dysfunction also or to poor anatomic position or immaturity of the pelvic organs. Dysmenorrhea is occasionally caused by rarer conditions.

Chlorosis, constitutional anemias, and secondary anemias often are associated with menstrualpathies and may be the etiologic factor. The blood condition must be carefully studied and treated. Blood counts on these cases should be routine.

Hypoplastic States. Hypoplastic states are becoming better recognized and somewhat better understood. These are the cases of anatomic underdevelopment, with belated maturity or underfunctioning, and are related to slow social maturity.

Few human bodies mature harmoniously, each part in proportion and in time relationship harmonious with the other parts of the same body. Witness the tall, lanky girl who later becomes the large, robust woman where the skeletal maturity preceded the full maturity of the muscular system.

These hypoplastic girls are not apt to be aggressive women nor have they a strong home-building urge. They tend to seek noncompetitive activities or positions where intellect and prestige give authority. It is rare to find such a condition among head nurses. These are the types of women who serve on committees but not as chairmen.

Women of hypoplastic constitution are usually "nice" girls. They are much besought by the male since they are usually the pretty type of girl who retains a youthful appearance beyond the average age. They may marry but are not greatly intrigued by the pelvic aspects of sex. Because of lack of urge they are not apt to philander. They may make comfortable wives because they seldom nag and are easy going. They may be fat or thin depending on the type of glandular deficiency. They are moderately sterile; it is hard for them to be fertile. They often miscarry their first pregnancy, but should be assured that with the second they may carry through. As widows they are failures because they lack the push and the fight necessary to take care of their children.

The menstrual history varies greatly but usually menses begin late, usually in the 15th to the 18th year, and the periods are irregular and delayed. Scant flow and dysmenorrhea are common. Other irregularities may be profuse, continuous flow or prolonged periods. Mid-pains and mid-bleeding are common. Often these patients, when they skip one or more periods at their menstrual anniversary, will show mental or nervous symptoms. They may become dazed or agitated. Epilepsy then is rather common. Girls in school may periodically become "problem" cases; if employed they may lose their jobs because of their conduct at these times.

In the young girl with menstrual disturbances, it is fully as important to make a complete general examination as in the case of mid-life or in older women where carcinoma is suspected. Because of sensitivity in the young girl, a rectal examination is preferable to a vaginal examination. Pelvic examination reveals that the genitals approach the infantile type, the parts being small, pale and dry. On rectal or vaginal examination the cervix is found to be hard and long and the body of the uterus small and hard. The ovaries usually are not palpable.

Hyperplastic Type. These girls present the opposite picture from the hypoplastic type. They begin their menses early in life, they have fully developed breasts and are more vigorous in general. Their treatment requires tact and understanding. They do not want to associate with boys and girls of their own age. Such girls need contact with fine, older women, not older men, because the too early matured girl may be so easily led into sex experiences.

They will marry young and after a short engagement. They are home builders and want their entire family about them. They are intense mothers, and will neglect their own health for their family. This is the type who must be commanded to have her lacerations and prolapse repaired.

Middle Types. There are two middle types—the normal and the constitutionally frail. These latter ones form the most of our pelvic invalids. They are below par in general health too, usually with low blood pressure and low resistance to infection.

In these constitutional inferiors there is poor response to therapy, whether it be surgery, cautery, drugs, glands, or advice.

Therapy. There is an increasing amount of scientific knowledge on glandular therapy, although research scientists tell us they are far from possessing a comfortable amount of knowledge on this interesting subject.

The modern trend is to give stimulating therapy instead of replacement therapy; for example, the giving of anterior pituitary for ovarian therapy

instead of ovarian extract for lagging ovaries. Endocrine gland preparations are delicate. Enteric-coated tablets by mouth are the most convenient. Hypodermic administration is the surest. Some few preparations may be given by vaginal suppositories. Some are stable, some must be kept in the refrigerator and some must be used promptly after manufacture. Single gland preparations are the most scientific. The anterior pituitary substance may be made from the pituitary glands of food animals or may be recovered from the urine of pregnant females.

For hypoplasia of the ovaries and uterus, anterior pituitary is most frequently used. The dose must be large. Headaches are the sign to cease medication for a while. Thyroid and whole ovary may be given as supplemental medication.

Thyroid medication should be preceded by basal metabolic test, cardiac examination and urinalysis, especial attention being placed on specific gravity. Thyroid medication should be interrupted—I order it for only five days a week and stop for two days. Clinical re-examination and laboratory tests should be frequent.

Whole ovary ordinarily is used in cases where the formation of the follicle is delayed or interfered with, the signs of which may be delayed menses or scant flow.

Corpus luteum is indicated for many conditions, such as when there is continued bleeding at each period, or at menopause, or for the vomiting of pregnancy, or for bleeding or threatened miscarriage in early pregnancy.

Because of the complexity of pelvic physiology and pathology, there cannot be any empiric prescribing applicable to all cases.

In some cases due to inflammatory changes, or if the uterine musculature is so poor as to give inadequate contractions, spasmotics or styptics are used. These are temporary measures.

Medical treatment may be insufficient in some cases who may then need hospitalization; for instance, when dilation and curettage is indicated. In cases of bleeding due to ovarian dysfunction dilation and curettage is very beneficial because the mechanical manipulations stimulate the ovaries to normal activity.

Inflammations. All inflammatory processes in the genital tract require careful investigation.

Routine examination of a catheterized specimen of urine is desirable. When it seems impractical or inadvisable to take a catheterized specimen a convenient method of obtaining a specimen is the following: I instruct the patient to take a douche or carefully wash away any vaginal secretion, then pass some urine to wash out the urethra; the last portion passed is collected in another vessel and is the specimen to be examined. Pus cells found in the microscopic examination of a specimen secured in this way are not mistaken for vaginal contamination. Blood Kahn is indicated for some cases.

In taking slides for vaginitis a urethral slide free from vaginal contamination will often give more information than the cervical slide. It must be remembered that the rectum is infected in almost 4 per cent of the cases of gonorrhea in the female, so it is well to take a slide from there in suspicious cases.

The hanging drop is used when examining for trichomonas vaginalis.

Local treatments for vaginitis and cervicitis must be thorough and frequent to get results. It is well to swab the vagina well with diluted green soap solution. Dry thoroughly and then paint all parts with the medication of choice. This choice varies with the condition. In trichomonas, methylene blue, but this needs to be supplemented with lactic acid douches. The combination works best because of the effect of acid reaction on the trichomonas. Since trichomoniasis sometimes is generalized in the bowels, urethra and bladder, local treatment may well be supplemented by constitutional therapy, in persons not known to be intolerant to arsenic.

In a virgin, where the hymen is still intact, douches by means of a catheter tip and followed by instillations of medication in liquid or ointment forms is advised.

Cervicitis, erosions and some cervical tears are best treated by cautery. Topical applications and tampons are not effective in most cases.

Foreign protein injections are most helpful in inflammatory processes of the tubes and ovaries, whether acute or chronic, specific or nonspecific. Aolan given in 7 to 10 cc. doses, two or three times a week, gives good results. Diathermy is helpful in some cases. I have had little success with vaccines.

Complications and Residuals of Pregnancy. In the office one sometimes sees cases of bleeding which, on examination, prove to be due to some obstetrical complication. It is sufficient to say that once diagnosed they are to be treated obstetrically or surgically.

Benign Growths. A very common pathologic finding in women of the thirties is the beginning fibroid. Diagnosis may be exactly established in the office. The duty then rests on us to prescribe a certain line of treatment. We should not put the burden of choice on the patient, such as whether she is to have x-ray or surgery. In our own minds, however, we may consider the pros and cons of surgery, x-ray, and radium.

The indications for choice are fairly well established, depending on age of patient, number of tumors, position in the uterine wall, whether bleeding or not, general condition of the patient, surgical risk, available time, and expense. Multiple fibroids, or one larger than a child's head, are not to be recommended for x-ray. Because of the risk of danger to the future generation, x-ray in child-bearing women is not to be lightly considered.

Where the fibroid is small and of slow growth, we may recommend regular examinations. If the tumor is not growing we wait until menopause naturally occurs before we intervene. Some shrink markedly after menopause. Surgical menopause causes a mental and domestic strain in many cases.

Sterility. This tragic state deserves the most painstaking examination and persistent treatment. Examination of the wife as soon after coitus as possible should include examination of a drop from the cervix and cervical canal to determine if there are live motile sperm cells present. If they are not found the husband should then be examined before going further. The reaction of the vagina must be taken, using litmus or some other indicator. After normal coitus the reaction of the vagina should be alkaline. If acid at this time, the patient should be instructed to take mild alkaline douches.

Sometimes the male discharge is found not deposited in a salubrious location as in certain cases of prolapse, or retroversion, or due to relative impotency of the male (ejaculatio praecox).

It is not proven that there is any best or "safest" time of the month for non-fertility, but the general human belief exists that the most favorable time for fertility is directly after the menstrual period is comfortably over. This warrants future study. There is no known scientific reason to believe that the absence of the nervous reaction of an orgasm is in any way related to sterility or fertility.

Lack of fertility of the ovum from endocrine insufficiency is to be thought of as a most important factor in sterility. In some cases a vague chemical incompatibility between husband and wife is the only explanation for sterility.

One of the most frequent causes of sterility in the female is the obliteration of the fallopian tube. This may be congenital or acquired. It may be due to hemorrhage or inflammation. In the absence of active, acute or recent inflammation the patency may be determined by the Rubin's test. Under controlled moderate pressure oxygen is passed from the cervical os into the abdomen. Using a stethoscope placed on the lower abdomen, if a bubbling sound is heard during the Rubin test, or if, when the patient sits up, she experiences pain as the air bubble strikes the diaphragm, then it is logical to conclude that the tubes are patent. She is instructed to have intercourse as soon as possible after the test. Pregnancy may ensue directly. The test thus is valuable because it is both diagnostic and therapeutic.

For diagnostic purposes only, an x-ray may be taken after injecting iodized oil into the tubes.

Contraception. While many women seek advice because they are sterile, some, for various reasons, seek contraceptive advice. Regardless of our views on the social aspect of birth control and the limitation of family, the physician recognizes that there are some diseases which contraindicate pregnancy. The woman physician with her knowledge of physiology and her familiarity with diagnostic methods should be the logical person to give contraceptive advice for these conditions. Contraception is a medical problem and should be in the hands of the medical profession.

There are many contraceptive methods and devices in use, none of them ideal. The method which so far has proved most successful is the vaginal occlusive pessary which has been properly fitted, used in conjunction with some good lactic acid jelly.

Educational. The woman physician is frequently called upon for advice in regard to marital and conjugal maladjustments. It becomes our duty to minister to the soul as well as to the body. Certainly this can be done very well by the married woman physician whose home and personal life is obviously wholesome and normal. There are many unfortunates who do not know what is normal, especially in marital relationship, either from ignorance, or from highly emotional shocking experiences in childhood which induce subsequent marital frigidity. Psychiatrists tell us that a well-born baby who is physically healthy will develop as a normal individual unless mentally traumatized by some malign adult.

Frigidity is most frequently psychic. However, it may be caused by endocrine inadequacy, in which case there are sufficient other signs and symptoms which determine the character of treatment. One thinks here of such things as estrogen and antuitrin. Frigidity wrecks many homes and it may be fatal because suicide is fatal.

Guidance for frigid women who are in good endocrine and physical health consists of instruction in their mutual conjugal physiology rather than making an attempt at psychoanalysis.

Sex relationship should be highly emotional. It should be full of tenderness and admiration for the mate. All intellectual thinking, especially extra-marital matters, should be dismissed from the mind at these times. The most dangerous habit is comparing the mate with a distant lover, actual or imaginary. Sex relationship is physiological and emotional, but it is not an intellectual process.

The height of the fullness of living occurs in ideal sex relationships, probably reaching its height during the first and desired pregnancy. Sexual heterodoxies in time or character have a marked tendency toward causing frigidity.

Menopause. The rugged natural woman whose pelvic history has followed the ancestral pattern of early marriage, only one husband throughout her sex life, where sex has become a matter of course, and she has reared a large family, has, relatively speaking, a menopause free from troublesome signs and symptoms.

The healthy single woman who has had no sexual excitement also has a rather gentle time at the menopause.

The woman in frail health who too often tends to discontinue all forms of pelvic activity in the thirties is as prone to menopausal disturbances as is the woman who has pelvic or associated disease. It would have been better for her to have continued normal sex habits if practicable and in accordance with tribal standards, even though she ceased to bear children.

The menopause tends to accentuate mild existing pathology. It excites the hyperthyroid and makes manifest the latent cases, who then become fretful, nervous personalities. It causes hot flushes and sweating in those with vasomotor instability. In some cases there are troublesome uterine hemorrhages and these patients must be dealt with individually. The treatment is symptomatic because the underlying causes may be constitutional or remote in the individual's life. Calcium in large doses given by mouth or intravenously sometimes gives instant relief of nervous symptoms.

Were the condition not self-limiting we would be totally discouraged by our therapeutic efforts. Glandular preparations and calcium are our standbys. Mild sedatives are frequently necessary over a long period of time.

Retrogressive States. In the retrogressive and pre-senile states the memories of all of us are painful when we recall those cases we have seen who later turn out to be carcinomatous. It behooves us to be on the alert constantly for all pre-cancerous lesions and to keep ourselves informed on any new researches which may help us check this malignant process.

Pruritis is often a very annoying persistent symptom in menopause and senility. Glandular products such as thyriod and ovary or pituitary compounds, local applications, and x-ray may be tried with varying results. Sometimes lowering of the blood sugar is attempted—but old ladies are like children—they love their bag of candy.

Conclusion. It may be said as a generalization that although women are predisposed to more than the average amount of ill health because of the delicacy and intricacy of their pelvic organs, yet the gynecologist, in office practice, finds that natural constitutional ruggedness and normal living predisposes toward comparative good pelvic health; and she finds that for the others who are not average that there is a continually growing armamentarium in radiant therapy, chemistry, biologicals, mechanics, minor surgery and psychotherapy, all suitable for office practice in gynecology.

THE COST OF MEDICAL CARE

C. P. EMERSON, M. D.
INDIANAPOLIS

How could medical men busily engaged in the practice of medicine, who were chosen because of their prominence in their profession, with abundant financial resources at their command, and with a carefully selected group of trained research workers to assist them, for five years have belonged to a committee studying the costs of medical care and have come to such diametrically opposed conclusions as did the doctors of the group whose report is now before us? On sociological and philosophical aspects of the subject they naturally might differ, but in this report the differences in their opinions involve the fundamental basis of medical practice itself.

Were these practicing physicians "led by the nose" by men with the medical degree but who had never assumed the responsibility for the professional care of a single patient? Certainly only those who themselves have actually been engaged in practice can speak with authority on the professional side of this subject. Nevertheless, our right to do so has in the past been repeatedly challenged.

Ever since that reform in medical education of thirty years ago which created the group of full time teachers in the preclinical subjects of anatomy, pathology and biochemistry, have the professors of these latter subjects assumed the right to select for University medical faculties the professors of medicine, surgery and of the practicing specialties, and later to dictate to them concerning their methods of treating their patients. The fault for this may in large part rest with the clinicians, since in America the professors of the clinical subjects, the most of whom also engage in private practice, have not, as a rule, devoted themselves as wholeheartedly or unselfishly to their medical school duties as have the preclinical men. The latter deserve the main credit of raising American medical education out of the slough of inferiority where it lay until the beginning of the twentieth century. For this splendid and self sacrificing service we accord them full credit; we praise them for the good influence they have over the entire medical faculty. But this does not make them experts concerning medical practice when an important constructive program for the future such as is this report, is being formulated.

Also, those men interested in social medicine, as the public health and social service groups, many of whom never studied medicine, have a very confident opinion of what medical care the community needs and how such service should be rendered. Of such there were several on this committee and we suspect that they were its aggressively active members. They were, however, largely "off their field."

On this commission were medical men well qualified from personal experience to judge of the problems of medical care itself. Why should they have differed among themselves in such diametrically opposite ways? Why, when practically all the others were unanimous, were they divided on a subject which concerned their particular field? Is it possible that their opinions were too much swayed

by the lay interests indirectly represented or by those men responsible for the splendid medical institutions and organizations which have meant so much for the medical care of the American people? We honor these generous laymen; we shall need their continued financial support. They alone can make possible some of the necessary reforms and adjustments which must be made if the American people are to be well served. But they should, we feel, follow the advice chiefly of leaders in the practicing profession and less that of the men in the preclinical or public health fields.

How most of the surveys made for this commission could have assisted these practitioners when they drew their conclusion is hard to see. For the most part these researches must merely have confirmed in terms of mathematics those opinions on which practically all of those actively engaged in practice must agree. That certain other researches made for them actually uncovered the essential points of the problems investigated, we doubt. The trouble is that these studies were not made by those who were to use them when they drew conclusions. It is an open question, we believe, whether this is ever justifiable. That man, and he alone, who makes the investigation of a problem, can draw safe conclusions from what is found. He alone who makes a research will, while he is making it, know whether or not he is getting at the essential facts, and he alone during his research will be led to other investigations which also must be made if his data is to be adequate to lead him to helpful conclusions. Hand the same report of a social research to two equally well qualified men who themselves have not personally collected the data, and on the basis of this they may arrive at radically different conclusions. Each will find that it confirms his previously held opinions. We fear that the physicians on this committee did not personally visit the fields surveyed; that they merely studied the reports of non-medical research workers who did the best they could, but who were quite without the "feel" of the subject.

The actual point of difference between the majority and the minority reports of this committee is, as we see it, largely to be read between the lines. The majority report implies that some controlling body (civic? financial?) will designate what organized group of doctors is to be responsible for the medical care of a given community, and will protect that group in its monopoly of its field. If so, then those doctors not fortunate enough to belong to such groups but who desire to practice in the same communities as they, and those patients who desire the medical services of these latter physicians, both will be conscious of a social control which will be fatal to the professional success of the former and which will be resented by the latter. If we understand the spirit of the minority report there is no objection to group practice as such. Groups are necessary and inevitable. Medical men always have worked in groups, some more closely organized than others. There often are several such groups in the same community. But these groups, like the several physicians who compose them, must stand each on its own merits. For any one of them to be officially recognized and protected in its monopoly of a general field of practice by any social force other than the group's own reputation is not for one moment to be approved. The officially created, controlled, or protected organized medical group may be necessary in an Army; it may be justified in an industrial colony; but never in an American community, the members of which are interrelated only by the geography of their residences.

ABSTRACTS

SMOOTH MUSCLE CONTRACTIONS OF SMALL BOWEL: DEMONSTRATIONS OF ACTIVE PRINCIPLE CAPABLE OF STIMULATING THESE CONTRACTIONS

MARTIN E. REHFUSS, Philadelphia (*Journal A. M. A.*, Dec. 31, 1932), presents evidence to demonstrate the presence of an active principle in the mucosa of a large part of the digestive tract capable of stimulating the smooth muscle contractions of the small bowel. By means of tissue extracts prepared with Locke's solution, this effect can be demonstrated in vitro on excised small muscle strips and in vivo by intravenous injections. Evidence is presented to show that this substance is not histamine, secretin or cholecystokinin, although it is closely associated with the latter. The author gives the preliminary report of an attempt to isolate such a principle.

RELATION OF RESPIRATORY INFECTIONS TO PUERPERAL INFECTION

JOHN T. WILLIAMS, Boston (*Journal A. M. A.*, Dec. 10, 1932), calls attention to the fact that surgical asepsis alone has not succeeded in stamping out puerperal infection. Other factors in the production of puerperal sepsis must be investigated. These fall into two groups: (1) those lowering the patient's resistance, such as excessive loss of blood and toxemia, and (2) those increasing the exposure to infection, such as respiratory diseases, vaginal manipulation and wounds (including both surgical incisions, as in cesarean section and episiotomy, and lacerations resulting from operative or nonoperative vaginal delivery). It has been shown definitely that the curve of the incidence of puerperal infection follows the curve of the incidence of respiratory infection, but at a somewhat later date. Every possible method should be adopted to guard the prospective mother from exposure to respiratory infections. This should include segregating her from crowds and, during the last month of pregnancy, from friends and members of the family with respiratory disease; culturing the throats of medical attendants and nurses at frequent intervals, and in enforcing the use of rubber face masks by attendants and nurses in the delivery room. The peak of puerperal infection is reached in March or April, more commonly in April. There is also an unexplained rise in June or July. August and May are the months in which the smallest number of cases of infection develop, but August, September, October, November and February were without fatalities from infection. From the standpoint of sepsis the period from midsummer to the beginning of winter is the safest time for women to bear children. The author concludes that while absolute elimination of infection in childbirth in the immediate future is improbable, if the problem is considered and attacked in its broadest aspects, it is not impossible that the next generation will see a reduction in the incidence of puerperal sepsis as striking as that of typhoid fever in this generation.

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FEBRUARY, 1933

EDITORIALS

DIAGNOSIS OF TUBERCULOSIS

Advice is easy to get. It frequently is cheap, and almost always is worthless when obtained free. Good advice on any subject, particularly pertaining to medicine, is always valuable, and outside of our own profession it is so rare as to be a curiosity when it is found unadulterated and given in good faith.

One of the finest suggestions ever given by a lay organization to the community in general is that the victim of disease should consult his physician early. No one can find fault with this advice.

The Tuberculosis Association, the Heart Association, and the Association for the Control of Cancer have been leaders in disseminating the knowledge of the value of an early diagnosis in these conditions, and for this work the community as well as the physician may be justly thankful. No informed person can feel too keenly that the ultimate success in the control of these diseases depends directly upon the early recognition of them, since they are so easily managed when found at the onset and are so hopelessly unamenable to known methods of treatment when found late. In the case of tuberculosis it is estimated by competent authority that there are about three-quarters of a million of active cases in the United States today. If this figure is erroneous it is probably too low. About one-tenth of this large group is under the supervision of sanatoria and private physicians and may be classed as controlled insofar as any case may be controlled at present. The other nine-tenths, or about 650,000 cases of tuberculosis, are, or will be, under the care of the general practitioner to whom the greater percentage of the patients go with their ailments, particularly those with symptoms, usually mild, which they have learned are the first evidences of disease.

It is interesting to note that the tuberculosis death rate has decreased from about 200 per 100,000 of population to about 65 per 100,000 during the last quarter of a century. This marked increase in the effectiveness of the efforts to control tuberculosis cannot be attributed entirely to improvements in therapeutics, as in such diseases as diabetes or pernicious anemia. It must be attributed for the most part to the general increase in the ability of both the physician and the patient to recognize the early signs and symptoms of tuberculosis and to begin treatment at once. Early diagnosis not only gives the patient a better chance for an ultimate recovery, but protects his family and friends from exposure by a few hygienic measures persistently carried out.

The general knowledge of the communicability of infectious diseases has done much to reduce the death rate from them, while the general physician remains the greatest single factor in finding the cases. This recognition of the early case often looks easy, but the differential diagnosis of the obscure chest signs is one of the most difficult procedures for the physician. When all of the modern facilities for accurate mechanical examination are available the problem is, even then, not an easy one, but when these means are either unavailable or, being available, do not come within the ability of the patient to pay, the responsibilities of the physician are increased many times.

Now, more than ever before, the physician is called upon to do expert work under unfavorable circumstances. During periods of depression patients will wait longer before seeking professional advice; they go to hospitals less often, and they return to offices less easily; adequate observation of any case is more difficult, and when home conditions are poor and food supplies may be reduced the necessity of finding out at the first interview all that can be learned becomes paramount. In this situation four things remain as ever the main standbys of the careful physician in the diagnosis of chest conditions, and their diligent application will reward him more than ever before. Everybody knows what they are, but during times of prosperity the simple things of life are neglected. These ever present, easily used and economically available facilities for chest examination are: first, the adequate history; second, the careful inspection; third, the expert use of the stethoscope; and fourth, the sputum examination. There are those who say that the stethoscope is out of date, that it is not accurate, and that too much time is taken up in an interview that exhausts the four subjects enumerated. Such beliefs are erroneous. Those people still are living in the "whoopee" years, unmindful of the general economic distress of the average man and regardless of which end of the stethoscope falls to his lot. There is plenty of time for the history and inspection. The sputum is easily and quickly stained and may give information more accurate than any other part of the examination. The use of the stethoscope should not be neglected.

Every patient presenting early symptoms of pulmonary disease will benefit by a most painstaking examination and by the use of the simplest of the diagnostic procedures.

THE REPERCUSSION

As was to be expected the medical and lay press is having much to say concerning the final report of the Committee on the Costs of Medical Care. The first press reports carried the story as being more or less of a news story—and it was a good story. Many metropolitan papers gave it a first-page position.

Now that we have had opportunity calmly to consider the entire report, to consider some of the far-reaching effects of the recommendations of the majority report, there seems to have been a marked reaction; the report does not bear the same roseate hue as at first glance. As was to be expected, organized medicine opposed the recommendations of the majority of the committee. It was patent that we could not carry on under the proposed plan without sacrificing much of the progress we have made in recent years, and many of our lay friends, now that our side of the question has been explained to them, are strongly impressed with the fact that the recommendations cannot be carried out without jeopardizing our professional future.

The committee has, however, rendered a valuable service to the profession; it has brought us to a stern realization that we have been fast asleep for many years; that our very existence has been and is being threatened, and that we have calmly sat by while this sort of thing was going on. In fact, we are many years late in realizing that sapping has been going on right under our very foundations. Just what we can do about it remains to be seen, but certain it is that we have our work cut out for us.

One of our greatest shortcomings is that we are slow in taking the laity into our confidence; for generations our profession has been shrouded in at least some degree of mystery. It is only in recent years that we have made any effort to publicize our achievements, to speak of the things we are trying to accomplish. True it is that some of our state associations are doing a most commendable work—Indiana is a leader in this field—through the very creditable work of its Bureau of Publicity. But even more active measures will have to be instituted to overcome the effect of the publicity given the committee report.

All of this convinces us that if we are to scotch the snake of state medicine and the paternalistic tendencies of our government we will have to quit this pussy-footing and get down to brass tacks. This is true not only of our state association but of the parent organization as well. The county society and the individual members of the profession have their work cut out for them. We have talked a lot; we have resoluted and resolved; we have admitted that something must be done about it; but we have accomplished very little in comparison to the publicity attending the release of the final report of the committee.

We have said that many of the laity are friendly to our cause; we could increase that support did we but put our case before them. Just recently we sat in a conference called to discuss this committee report, there being several laymen in the group. Without exception these men were agreed that the adoption of the recommendations of the Majority Committee would be more than inimical to the best interests of our community; that it would so curtail our professional activities as to result in disaster. One man, whom we have known as a keen observer, made the point that such a proceeding would destroy much of our initiative and would practically paralyze medical and surgical research. He was of the opinion that the lay public would almost unanimously support our position *if we would but put it before them.* He then proceeded to take us to task, in a rather severe manner, for sitting idly by during the past five years while the investigations leading up to the report were being made.

We have always maintained that we can and will have the support of the public in any of our worthy undertakings. This has been proved on so many occasions that it is almost axiomatic. No one can make better contacts than the individual physician because of his personal relations with his patients, many of whom will be very glad to render assistance in such matters as the case in hand. We should not enter into a long-winded discussion of medical economics with all of our patients, but all of us have frequent opportunity to talk things over with thinking people. True it is that our association committees are doing splendid work and will do better work as they become more intimately acquainted with the problems before them, but the time has come when we cannot rely solely on such committees. The individual must take an active part. It is to be a long fight and a hard fight and we can win only by each of us donning his armor and faring forth to give all that is in him. Especially should the younger men be interested, for it is, in the main, their fight; the older group will not see many of the changes that now appear in the offing.

THE JOURNAL will do its part; it will give space to suggestions; it will continue to hammer the matter home as best it can. However, this is no one man's fight, nor is it the battle of any group or groups; it is a battle that must be waged all along the line and in which we all must participate. Do not sit idly by, smug and content, with the inner feeling that "I do not see that I should get unduly excited about this thing, for it will not affect me." Unless we get busy, unless we do something more tangible than we have done, and unless we acquire more friends among the laity, this THING, this specter that confronts us, *will* affect every one of us.

ENCOURAGING YOUNG MEN TO STUDY MEDICINE

It speaks well of the profession that physicians should wish their young friends and their sons to study medicine, but we wonder whether it is right that we should do as much proselyting as has been done in recent years. The situation has changed a great deal since Dr. Pusey advocated that we should greatly reduce the requirements so that more young men could graduate from medicine. He foresaw a great lack of physicians. The fact is that this country is much better supplied than other countries, and if the truth must be told, it is undoubtedly oversupplied at the present time. There is still room for the unusual chap; there is still room for the lad who studies medicine because he can't help himself. There is no room for the young man who has low or ordinary qualifications; and there is no room for him who studies medicine because other folks want him to do so and he hasn't the backbone to refuse. The requirements are high and they are getting higher. There is a lot of grief in store for the chap who thinks medicine an easy road to wealth, social position, and a white collar.

Strangely enough—and it speaks well of the coming generation—the harder the schools make the courses the more determined a lot of fine young people are to get into medicine. This is exactly as it should be. Quality attracts quality. It really is not fair to the real students to make the courses so easy that anyone can pass them. It is as much the purpose of a well-poised medical school to keep some people out of the profession as it is its duty to prepare others for it. Many of the medical students are coming out of high school, taking two years of required premedical work, four years of medicine, and by the time they are twenty-three or four they are proudly wearing the title which an M. D. degree bestows. Most of them haven't the slightest idea what it is all about. A great many of them have been sent to school simply because dad had the money and mother thought it was the thing to do. We believe that boys should not decide to study medicine until they have either finished a liberal arts degree in a university, or have been put through some of the courses in the school of hard knocks. Furthermore, we believe that they should make the decision and that they should make it without any pressure whatever being made in favor of medicine.

Medicine is supposed to be a very *interesting* work. It is—sometimes. However, we can think of nothing more deadly in its monotony than routine examinations of various sorts and of listening to the tales of woe of those who really are sick and those who think they are sick. It is supposed to be a *genteel* profession. That's a laugh. The average physician does things that the garbage collector probably would refuse to do. It gives *social* position. Yes, and when you go to a dinner party or a theatre you are listening with one ear to the telephone and probably will get the call before the evening is over. It is *good pay.* How many physicians do you suppose there are in Indiana who are really rich and who have made the fortune honestly and without the aid of father's inheritance? We doubt if there are twenty-five. There are a lot of other nice things that the practice of medicine is supposed to be, and in every one—save one—there is a big, black fly in the ointment. There is but *one* legitimate reason for studying the art and science of medicine, and that is a burning desire to be of service to one's fellowman. If this desire, like the ghost of Banquo, will not down; if it will not let the pilgrim sleep, or eat, or live in peace; if it bobs up here, there, and every place, in a dozen different guises, it means that he, provided he has health, brains and will, is one of the elect. Otherwise he had better take up something a lot less vital than this business of delivering babies, chiseling out necrotic mastoids, and diagnosing heart lesions.

FINAL REPORT OF THE COMMISSION ON MEDICAL EDUCATION

We recently have been much concerned with the report of the Committee on the Costs of Medical Care, and for what apparently seems to be mighty good reason, have had much fault to find with it. Of course the minority report offers some consolation to the profession, but it is very doubtful if many people will ever hear of the minority report inasmuch as it is nearly sure to be covered up intentionally and unintentionally by the voluminous literature which is included in the majority report and the discussion thereof. If the argument concerning these two reports has not already saturated the reader with material of this sort, we should like to call attention to the "Final Report of the Commission on Medical Education." The committee which has gotten together this report is composed for the most part of men who are eminent in medicine and allied sciences. It includes some four or five deans and former deans of medical colleges, two or three college presidents, and some six or eight other distinguished scholars. Organized medicine is represented by William Allen Pusey, former president of the American Medical Association, and Olin West, Secretary of the American Medical Association. On the committee are four persons who have been presidents of the Association of American Medical Colleges and two who have been presidents of the American Medical Association. It is intended as an exhaustive study of undergraduate and postgraduate medical education and includes a careful study of the matter of supply and distribution of physicians. The various courses in the curriculum of the medical school are subjected to criticism and the attempt is made to point out what needs to be done to bring these subjects up to the highest possible plane. The report

takes the position that the first and most important function of the medical profession is to serve the community and mankind in general, and that when this is done the profession should be well paid so that the more capable young people would be attracted to medicine not only as a service but as a remunerative career. Mention is made of the fact that forms of medical practice are changing and that medical schools and medical practitioners will have to adapt themselves to that situation as a fact and that it will be much better if the profession interests itself in the various forms which the change may assume. It is certain that a change is taking place and the profession will do well to make a strenuous attempt to guide that change into safe channels. The report is opposed to the state or government entering into the active practice of medicine except when necessary to care for indigent patients. The report does not, however, denounce all forms of so-called health insurance but condemns only those which would take away from the patient his right to choose his own physician and take away from the physician the right to hold a personal relation to his patient.

The report consists of some 400 pages and 161 reference tables, and it is therefore quite impossible to give any of the detail in an editorial. We simply commend it to those members of the profession who are interested in the various social aspects which are now interesting the profession in regard to the profession itself. It can be had by addressing Willard C. Rappleye, M. D., Director of Study, 630 West 168th Street, New York City. The book is undoubtedly worthy of very serious consideration and study on the part of those who are responsible for, or have any interest in, medical education and the relation of the profession to the public. Personally we believe it to be very superior in content and wisdom to the Report of the Committee on the Costs of Medical Care.

EDITORIAL NOTES

DEAR DOCTOR:

THE JOURNAL and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital.

We invite and urge you to use this Service.

It is absolutely *free* to you.

The Cooperative Bureau is equipped with catalogues and price lists of manufacturers, and can supply you information by return mail.

Perhaps you want a certain kind of instrument which is not advertised in THE JOURNAL, and do not know where to secure it; or do not know where to obtain some automobile supplies you need. This Service Bureau will give you the information.

Whenever possible, the goods will be advertised in our pages; but if they are not, we urge you to ask THE JOURNAL about them, or write direct to the Cooperative Medical Advertising Bureau, 535 N. Dearborn St., Chicago, Illinois.

We want THE JOURNAL to serve *you*.

WE get a kick—sometimes a thrill—out of some of the mail we receive; we always have time to answer correspondence and we sincerely court your opinions. Your editor has been more or less active in association work for more than a quarter of a century, and in that period he has acquired the hide of a rhinoceros, so—shoot your stuff! We are sure to profit by it.

SOME of our county secretaries send out snappy notices of meetings. Recently we received one from Jay County that was especially good, and we will wager that it resulted in a good attendance. Formal notices, full of dignity, may and do have their places, but our observation has been that a little pep, properly distributed, in such bulletins, has a tendency to attract the notice of the most hardened member. Put a little "meat" in your notices of society meetings.

MOST physicians who are just beginning the practice of medicine do not know just how to go about the business of affiliating themselves with the proper medical societies. Some think they must be invited to apply for membership. If secretaries will invite eligible young physicians in their counties to attend meetings, and then take the opportunity to explain the manner of applying for membership in the county medical society, both the young physicians and the medical society will benefit.

IT is indeed encouraging to have another radio broadcast which helps to offset the pernicious advice of charlatans and the patent medicine ballyhoos. We have just listened to the E. R. Squibb & Co. hour which will be given every Sunday at 3:30 p. m. This is a most advantageous time and assures a good audience. It portrays the dramatic incidents of the history of medicine and particularly gives due credit to the value of the general practitioner. It again stresses the worth of a medical examination and protests against self-medication. We are fortunate to have such high class radio advertising.

OUR contention that the Veterans Bureau should utilize existing local hospitals with their 38% of empty beds, instead of building more and more Government hospitals, has received conspicuous support in an editorial in the Saturday Evening Post of January 7th. It is inconceivable that a rational tax payer could disagree with this common sense solution. The article in the Post brushes aside the specious figures and statistics put out by the Veterans Bureau and very simply and forcibly shows how the average sensible citizen should view the situation. Surely this additional widespread publicity should help us convince Congress as to the justification of our claim.

THIRTY years ago it was thought that cancer was a disease peculiar to man. The fact that animals suffered from cancer was not recognized. As the result of a great deal of research work, Bashford and Murray were able to prove that cancer occurs throughout the vertebrate kingdom, and that in its general biological and pathological features cancer in vertebrate animals is subject to the same laws that govern its incidence in man. Its occurrence is most frequent, both in man and in animals, when the subject is in advanced years. Cancer is thought to be about fifty times less frequent in young people than in middle aged and old people.

SOME newspapers have interpreted the Report of the Committee on Costs of Medical Care to mean that the selection of a good physician is dependent upon the good judgment of the individual; and also that the nation is suffering from a shortage of *competent* doctors, dentists, and hospital facilities. Could anything be further from the truth? Surely, competency is not lacking, and there seems to be a shortage of nothing in these good old United States except employment. The publicity given the various phases of this report will make John Doe suspicious of his own family physician, to whom he has entrusted the care of his family for many years. It will create more unrest, more dissatisfaction—what has been gained?

MONILIA infection, we have had occasion to discover recently, is rather unknown to the average doctor in Indiana. To the present day medical student and to a few specialists it is familiar and included in their diagnostic repertoire but as yet unheard of by the mass of practitioners who graduated twenty or thirty years ago. We are of the opinion that these sub-tropical fungus infections are being brought into our state by the facilities of transportation. Not so many years ago trips to Florida and the Gulf were rare luxuries indulged in by the rich, but now automobile journeys are so common that a few days' jaunt to the Southland is a frequent experience. The continuous hitch-hiking up and down the country brings to our offices patients with skin infections and diseases entirely foreign to our previous knowledge.

IT seems that any attempt to defraud will have at least one customer—but the customers are getting wiser. Recently an old fellow in Indiana attempted to persuade a young man to "study under him" to learn the "elimination of parasites" which was designated as a specialty requiring knowledge in no other branch of the healing art. The young man, desiring to be a "doctor" controlled his enthusiasm long enough to write a letter of inquiry to the State Board of Medical Registration and Examination and, when told that he could not obtain a license to practice in Indiana without attending a recognized college, and to practice without a license would result in his arrest and prosecution, he promptly abandoned the idea of learning the methods practiced by the old man. If laymen are beginning to realize that there is a Board, we are progressing.

A LETTER from a "small town" practitioner appeals very much to us. He wrote his comments on our first issue of THE JOURNAL, and in closing said: "The appeal for good county society papers is most constructive. Some of us would like to break into print and thus attain some ability in writing. No surer evidence of error can attain than to read one's own efforts. No surer method of determining the value of an effort than to ask 'Who will benefit from this effort?'" As we said in our first issue we want the support of the entire membership and we want well-prepared papers, regardless of whether they were read before a large group or before the "home" society. We are strong for the county society; we have reason to believe that often the best papers are those prepared for home consumption.

THERE are 10,091 inmates in the eight Indiana state institutions for mental cases. During the past year new patients were received at the rate of 135 a month—1,623 altogether. More than fourteen and one-half million dollars is invested in the land, building, equipment and supplies of these eight institutions, and the cost of maintaining them for one year is two and one-half million dollars. There is an increasing demand for admittance to these institutions. Are we locking the barn after the horse has been stolen? Building more institutions, making more accommodations for more mentally defective people who might be useful members of society if given proper attention, at the proper time, it seems to us, is attacking the problem from the wrong end. The Indiana Society for Mental Hygiene is working for prevention, for "the conservation of mental health and the prevention of mental disease and mental defect." May such efforts meet with huge success!

WE used to wonder just how much THE JOURNAL is read; whether, as Morris Fishbein says, the obituaries and news notes are commonly read, but much of the scientific section is overlooked. We have come to believe that THE JOURNAL is pretty well covered by the average reader, and our opportunity for such observation has been very brief. Soon after our appointment was announced, even though we did not take over THE JOURNAL for some months afterward, we began to receive letters from members from all sections of the state. Some of these were commendatory, some were quite critical and some were outright antagonistic to ideas expressed here and there in THE JOURNAL, with none of which we had had any personal connection. All of this is quite pleasing to us. We

like to be told what our folks think. If you do not agree with some of our expressions we want to know about it; if you dislike any of our regular features as now appearing, tell us about it; as we said in the first issue, we are but your servants and this is *your* JOURNAL.

THE Judicial Council, in its efforts to deal with the many problems submitted for its consideration, has been mindful of the fact that it is a very serious matter when it is proposed to overturn the age-old traditions of a profession, to institute new and unproved methods of practice, and to establish an entirely new basis of public and professional relations. The complexities of modern society may make it imperative that some changes shall be made, but the duty of the organized profession is to see to it that any and all proposals for change, from whatever source, shall be scrupulously and deliberately examined with the view of determining their ultimate value. Decisions should not be made on the basis of feasibility for the immediate present but should be made in the light of the experience of the profession, the nature of its service, the imperative need for maintaining professionalism and the absolute necessity for unhampered scientific advancement, and with the utmost regard for the best interests of the people.—*From Annual Report of Judicial Council, 1932.* A. M. A. BULLETIN, November, 1932.

IN these modernistic days one hears of "rackets" in almost every field of endeavor and we have been congratulating ourselves that the medical profession has not gone in for this sort of thing to any great extent. However, with the unfortunate and uncalled-for publicity attending the discussion of medical poor relief and the much-publicized report of the Committee on the Costs of Medical Care, we are open to suspicion in the minds of many of the laity. We are not wholly blameless in this regard; too often do some of us transgress the very laws of ethics that have preserved the profession throughout the years; too often do we forget the little niceties of the profession and engage in practices that merit criticism. Only recently complaint has been entered, and this is but one of a series of similar offenses, that some of our members are too much interested in the successes of some of their legal friends, going so far as not only to recommend that the services of a certain firm be engaged in a damage suit, but to personally escort the claimants to the office of their favored attorney. The evidence is so voluminous and so direct as to leave little doubt as to the merit of the complaint. Such practices can be carried on for but a short time without the facts becoming more or less public, and the attendant publicity can but reflect on those engaged therein. Somehow or other we believe in playing "four square" in our professional relations, even though occasionally we may be omitting a chance to make a few extra dollars.

J. C. GEIGER, of San Francisco, in the THE JOURNAL of the A. M. A. for December 3, 1932, reports four cases of cyanide poisoning. Three of the patients died under the treatment instituted, i. e., stomach lavage, artificial respiration and cardio-respiratory stimulants. The futility of the treatment instituted led Dr. Geiger to ask Dr. P. J. Hauzlik, professor of pharmacology in the Stanford University School of Medicine, and Dr. C. D. Leake, professor of pharmacology at the University of California Medical School, to make a survey of the treatment of poison cases of all kinds as practiced at the Emergency Hospital Service of the Department of Public Health. This survey resulted in the issuance of an outline of the antidotes in use at the present time by the Emergency Hospital Service of the Department of Public Health in all cases of poisoning. From this outline Dr. Geiger learned that intravenous injections of 50 c.c. of a one per cent sterile aqueous solution of methylene blue was the antidote for cyanide poisoning. Therefore, when the fourth case presented, this method of treatment was instituted and resulted in recovery of the patient within a few minutes. Dr. Geiger says there is evidence in the literature which warrants the use of methylene blue in carbon monoxide poisoning as well.

BACK in the days of ovariotomies and Thomas pessaries we thought a genito-urinary specialist was merely a "clap doctor" taking on airs. Notebooks covering that year's lectures and that specialty contain no less than six good prescriptions for the local treatment of gonorrhea. Among our early cases was one of gonorrheal prostatitis, and it is safe to say that the physician suffered as much as did the patient in that instance. The old grocery bill was allowed to ride while we purchased books on genito-urinary diseases, and through the information gained from these books and Gray's Anatomy, the ideas held concerning "clap doctors" were radically changed. No doubt there are prostatic hypertrophies, cancers of the prostrate and peculiar types of prostatic enlargement, that demand enucleation or other surgical treatment to give relief. We have no criticism of these procedures. All too often these sufferers come to the specialist disgustingly dirty; they have had no treatment directed toward cleansing of the urinary tract, lessening the congestion about the prostate; they have had no advice as to rest, diet, clothing, stimulants, etc., that might relieve pain and maintain a way of egress for urine. These patients have long stays in hospitals, getting clean enough to risk an operation. We never advise extremely large amounts of water, because of the belief that good does not follow any excess. Worries, overwork, long hours—all must be managed. Certain occupations, such as riding in hard-seated trucks, must be avoided. The individual patient must be studied.

A Medical Commission. In accordance with the fashion of the day for investigations by commissions a medical commission was set up and financed by several foundations, chiefly by the Rockefeller Foundation. After putting in about eight years on the investigation, at a cost of a million dollars, the report has been published. It is a very elaborate affair, exceeding that of the Laymen's Foreign Mission Inquiry; also chiefly financed by Mr. Rockefeller. The majority report proposes a kind of socialization of medical service, and this has been received with general dissent by physicians. The minority report opposes this plan. The report says that there are too many physicians in the country by 25,000. Only two medical men were on this commission and a lawyer was its chairman. Now let a commission of laymen with a physician as its chairman, and financed by Mr. Rockefeller, be appointed to investigate the legal profession, and they could bring in an almost parallel report, recommending that the profession be socialized and telling us how many lawyers there are in excess of the public need; what an uproar there would be among the lawyers! And let a similar commission with a minister as chairman be appointed to investigate bankers, and a commission to investigate the ministry be appointed with Mr. Darrow as chairman, and so on. It is a great day for commissions of investigation by outsiders, and there is still plenty of money in Mr. Rockefeller's ample purse.—From THE PRESBYTERIAN BANNER, December 29, 1932.

A Sensible Plan. The proposal of the Lake County Medical Association to divorce the care of township indigent patients from the blighting influence of politics is the most sensible that has been advanced thus far.

According to the association's plan a rotating committee of three reputable physicians would be elected for alternate terms of three months with virtual control over township medical aid.

This committee would permit family physicians to treat indigents whenever possible. It also would study each case, diagnose the treatment if necessary, and then allot payment to the attending physicians from a stipulated monthly total on the basis of an ingenious, but thoroughly practical, point system.

Under this scheme, the township trustee and the township advisory board would exercise only supervisory power. The county commissioners, too, would be relieved of the necessity to scan each medical claim.

Claims would be submitted to the commissioners by the committee only after they had been approved by a majority of the committee members.

In other words, the township divisions of the Lake County Medical Association would supervise and control medical poor relief and not the trustee or the township advisory board. That would remove this phase of the trustee's duties from political control.

We can think of no better plan than that. It certainly would be an improvement over the present method of doling out medical plums to physicians in conformance with the discredited "spoils" system.

Then, too, the Lake County Medical Association would be more eager to protect the integrity of its profession than would a township trustee; for the latter usually is interested only in the political significance of each appointment.—LAKE COUNTY TIMES, Hammond, Ind.

THE medical advisory council of the Indiana University School of Medicine, composed of Drs. Joseph M. Barry, George S. Bond, Louis Burckhardt, John W. Carmack, E. D. Clark, Frank W. Cregor, William P. Garshwiler, A. B. Graham, Frank Hutchins, Daniel Layman, Robert Lyons, John A. MacDonald, Arthur M. Mendenhall, William Moenkhaus, Burton D. Myers, Thurman B. Rice, Frank Walker, Matthew Winters, William N. Wishard and W. D. Gatch, has adopted resolutions concerning the report of the Committee on the Costs of Medical Care, as follows:

Whereas, The medical profession has tried diligently to maintain the high standards of the past to the end that the welfare of the patient and the public might be protected in all essential matters, and

Whereas, The relation between physician and patient is one that is essentially intimate and private, a relation which can exist in its best form only between individuals, and

Whereas, The modern trend toward the socialization of medicine may tend to disturb that relation, we, the advisory council of Indiana University School of Medicine, do hereby resolve,

That we do approve and indorse the efforts of the American Medical Association, the Indiana State Medical Association and many other organized medical societies to foster and maintain the high individual standards of the past and to curb or control the present tendency toward such forms of medical practice as may possibly interfere with the right of the patient to choose his physician and the rights of the physician to make a private arrangement with the patient or his family.

As an educational body, we are much concerned with the maintenance of present high standards of medical practice and research and we fear that if tendencies to socialization of medical practice should grow, the profession of medicine would cease to attract the outstanding men of our college of arts and sciences and that the splendid advancement of medical practice and research of the country would be checked.

Resolved, also, That Dean Gatch be instructed to send copies of these resolutions to the various medical colleges of the country.

THE PRESIDENT'S PAGE

It is gratifying in traveling over the state, visiting county and district society meetings, to note the increased interest in medical organization. It was my privilege during 1932 to accompany Dr. Crockett and observe the increase in attendance and enthusiasm for closer co-operation among the doctors.

Three things I believe are responsible for this, the dynamic sincerity of Dr. Crockett, the threat of socialization of medicine, and the depression. It is my earnest hope I may during 1933 be able to continue the first cause, that the second and third will fade and disappear, and that we will have become so imbued with the advantages and necessity of organization that no professional or economic threats will be necessary to keep us united. Some good, I feel sure, will come out of the report of the Committee on the Costs of Medical Care.

For many years various plans and schemes have been adopted for the care of the indigent sick. An adaptation of the Iowa plan (in operation for about twenty years) is being gradually adopted by counties in Indiana. One of the latest recruits is Howard County. The president of the county society reports satisfactory results. For such a plan to be workable, the county society must be a unit, everyone loyal and all working together. Efficiently handled through the society control, it is absolutely fair and equitable to each and every member, the poor receive better care, and the cost to the county is no more than the proper proportion to the cost of food, shelter and clothing.

It is not right for physicians to receive no pay. Merchants always have been paid, and it is high time to put a stop to the exploitation of the physician. If the individual physician refuses to deal with the trustee and demands that all contracts be made with the county society, the question of the indigent sick will be handled to the satisfaction of the doctor, the patient, and the public.

It is highly important to watch all the schemes being pushed for group hospitalization. The plans are various, but are all based on a fixed payment plan, and while theoretically there may be some merit in them, they are basically undesirable because it is one more step along the line of socialization.

If the doctors will stand united as opposing any such schemes until their soundness is proved and approved by the medical profession, the hospital cannot afford to adopt them. Hospitals exist not for the convenience of the doctor, but for the opportunity they afford for better care of the sick. They would be just so much brick and stone without support of the physician. Hospitals are not suffering during this depression any more than any other business that overexpanded during the boom. We physicians are willing and anxious to do our part towards their recovery, but we must not sanction nor abet any schemes that may have repercussions to either physician or hospital.

The Committee on the Costs of Medical Care is very active now contacting civic clubs, women's clubs, ministers, social workers, etc., with a veritable bombardment of literature and propaganda. Each one of us should thoroughly inform himself of the activities being pushed in his locality. He should not stubbornly oppose, but on the contrary work with them and show them the fallacies, shortcomings and dangers in the plans. It is not wise to inaugurate opposition, but keep awake, watch, look and listen. At the first signs of interest or activity, then begin the campaign of education in opposition.

The legislature is in session. Though there is much that should be done in improving and changing medical and health laws, this year is not the opportune time. This session will be greatly consumed by economics, especially economies, and very likely scanty attention will be given to other matters. Nevertheless, the cults are busy trying to crash the gate, and it behooves us to be on the watch and ready for instant action.

The Legislative Committee is already on the job, so when they send an S. O. S., respond, and quickly. It is only by concerted action that we can preserve and protect the medical practice and health laws. The members of the committee may need your help at any time. Don't fail them.

The Committee on Business Instructional Course has been active, and arrangements are completed for several lectures to be delivered to the seniors during the next semester.

We should be justly proud of our Journal. The complete change of management, complete change of mechanical set-up, change of date of publication, etc., seemed almost insurmountable. But THE JOURNAL appeared on the date promised, the technical make-up of the highest quality, the scientific articles good, and the editorial department handled as ably as a veteran editor might. The editor, assistant editor, editorial board, business manager and printer, each severally and jointly, deserve our praise and thanks.

I wish, along with the editor, to impress upon you that this is your Journal. Write it about your problems, your ideas, your suggestions. The officers want THE JOURNAL to reflect the society. Everyone help.

JOSEPH H. WEINSTEIN, M. D.
TERRE HAUTE

SECRETARIES' COLUMN

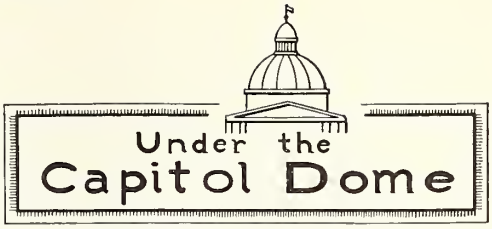
Here we are, still in the hands of the other fellow practicing medicine. In other words, the other fellow is dabbling in our business. You know that a man would have all he could do if he only took care of himself. The latest thing I have reference to is the 40-8 society attempting to immunize every child in the country against diphtheria. It is a good idea to rid the United States of diphtheria, but why do they want to do it, and how are they going to do it? See the January issue of the Forty and Eighter, their official publication, for full details of the idea. Look around and see how your local 40-8 propose to handle the situation, and then report to Mr. Hendricks at once.

We want to thank Dr. E. H. Cary, president of the American Medical Association, and J. Milton Robb, president of the Michigan State Medical Association, for addressing our Secretaries' Conference on January 22, 1933. This was perhaps the best conference we have had.

How many counties have had a meeting with some community organization regarding the recommendations of the Committee on the Costs of Medical Care, and what has been the result of these meetings? Please report to the office of the State Secretary—Mr. Hendricks. He needs the information.

The State Committee on Health Insurance recommends that each county medical society have at least two meetings this year on economics. Already several counties in the state have had one meeting on this subject. Also each county secretary should report the results of the meeting to the headquarters office of the Association. This information on taking care of the indigent poor, group hospitalization, etc., is very valuable. Did you read Tom's letter of January 12th on this subject? Did you receive and read Confidential Bulletins Nos. 1 and 2, on the legislature? Have you been able to get your legislators to express their opinions about the medical profession? If not, you had better get busy. You know the cults are working, and there is great agitation for some form of health insurance.

E. M. S.



Much important legislation affecting the public health and medical profession undoubtedly will be introduced in the General Assembly this year. According to routine procedure, legislation of this character will be referred to the Public Health Committee in the Senate and the Committee on State Medicine and Public Health in the House.

The make-up of these committees as announced by Lieutenant-Governor M. Clifford Townsend and Speaker Earl Crawford follow:

Senate Committee on Public Health

Name	Address	County
Geo. D. Miller, M. D., *Chairman*	Logansport	Cass and Fulton
Jesse M. Ballard	Marion	Grant
John C. Gorman	Princeton	Gibson and Pike
T. A. Gottschalk	Berne	Adams, Blackford and Wells
Isaac N. Trent, M. D.	Muncie	Delaware
Curtis E. White	Indianapolis	Marion
Floyd I. Garrott	Battle Ground	Benton and Tippecanoe

House Committee on State Medicine and Public Health

Name	Address	County
Bern B. Grubb, *Chairman*	W. Lafayette	Tippecanoe
Wm. F. Schenk, M. D.	New Corydon	Jay
Chas. J. Allardt	South Bend	St. Joseph
E. Millard Dill (*Dentist*)	Plainfield	Hendricks
John W. Mertz	Corunna	Dekalb
Ray Gilbert	Seymour	Brown and Jackson
Thos. A. Hendricks	Indianapolis	Marion
Paul B. Sturm	Dana	Vermillion
Henry C. Asche	Sunman	Dearborn and Ohio
Herbert H. Evans	Newcastle	Henry
John W. Weaver	Elnora	Daviess

* * *

The annual chiropractic bill has been introduced in the legislature. It is practically the same as the chiropractic bill of past sessions in that it provides for a separate chiropractic board. Such legislation, of course, means the lowering of standards in the practice of medicine throughout Indiana. The representatives who signed this bill follow:

Byron Radabaugh, Marion, R. No. 6, Blackford and Grant.

Balthasar Hoffman, Valparaiso, Lake and Porter.

Ira Eshleman, Elkhart, Elkhart.

Edward J. Braun, Fort Wayne, Allen.

Fred S. Galloway, Indianapolis, Marion.

J. Frank Regester, Bloomington, Monroe.

Henry C. Asche, Sunman, R. No. 2, Dearborn-Ohio.

It is understood that several other chiropractic and naturopathic bills are being considered for introduction.

The 1933 medical examination will be given June 20, 21, and 22.

* * *

A resolution which provides that all internes in Indiana hospitals must have licenses from the Indiana State Medical Board is being prepared by the Board. Motion to have the resolution spread in records of the Board was made at the January meeting by Dr. William R. Davidson, of Evansville.

* * *

The Indiana State Board of Medical Registration will be represented at the annual Congress of the Federation of State Medical Boards by Dr. J. W. Bowers, of Fort Wayne, the newly elected president. The 1933 Congress will be held in Chicago this month.

* * *

Dr. J. W. Bowers, of Fort Wayne, was elected president of the State Medical Board at a meeting January 10. Other officers who will serve during 1933 are Dr. J. B. Kinsinger, of Rushville, vice-president; Dr. William R. Davidson, of Rushville, secretary; Dr. Cecil J. VanTilburg, of Indianapolis, treasurer, and Miss Myrtle Griggs, of Indianapolis, clerk.

* * *

The State Medical Board is on record as approving a resolution adopted by the Federation of State Medical Boards relative to the admission of American students in foreign medical colleges and the requirement that those students shall obtain a certificate showing that they have met the premedical educational requirements of the Association of American Medical Colleges.

* * *

The Association of American Medical Colleges is expected to approve the reorganization plans of the Eclectic Medical College of Cincinnati, according to B. H. Nellans, secretary of the school, who was in Indianapolis to attend the January meeting of the State Medical Board. Mr. Nellans said that Pennsylvania and New Jersey already have given their approval of the school.

* * *

Dr. William R. Davidson, secretary of the Indiana State Board of Medical Registration and Examination, has brought to the attention of members of the legislature the necessity for increased funds to be placed at the disposal of the Board. Dr. Davidson asks that the Board be given a budget of about $6,500 to $7,000, free from the present limitations. Since 1897 the Board of Medical Registration has turned in to the general funds of the state the net amount of $11,571.11.

* * *

Preparations for a hearing on charges for revocation of the license of John DeRoahn, a drugless healer of Indianapolis, have been made by the State Medical Board. Investigation by a representative of the Board showed that DeRoahn has been convicted in the Marion County Criminal Court on a charge of performing an illegal operation on a sixteen-year-old high school girl and was sentenced to serve three to fourteen years in the Indiana State Prison, and ordered to pay a fine of $100. A motion for a new trial is pending in the court. As soon as the question of an appeal or a new trial is settled, a hearing on the license revocation charges may properly be heard by the Board.

* * *

Members of the Indiana State Board of Medical Registration and Examination and the Indiana State Board of Health were among the first state officials to call upon Paul V. McNutt, Indiana's new Governor, and extend him a welcome, pledge him their co-operation, and wish him a successful administration. Both boards arrived while the Governor's office was still resplendent with flowers sent by friends throughout the state and by organizations with which Governor McNutt is affiliated.

Members of the Indiana State Board of Health are Dr. T. W. Oberlin, Hammond; Dr. A. C. McDonald, Warsaw; Dr. John H. Hare, Evansville; Dr. F. W. Cregor, Indianapolis; and Dr. William F. King, Indianapolis.

* * *

At the close of the fiscal year, Mr. Brown reports, Indiana was caring for a total of 19,731 persons in all state institutions, including homes, schools, hospitals, and penal and correctional institutions. The institution population at that time was 645 more than it was on the same date a year ago. The largest increase in institution population was at the Indiana State Prison at Michigan City which was housing 2,531 prisoners at the close of the fiscal year, September 30, an increase of 108 over the population at the close of the preceding fiscal year. The Woman's Prison, by comparison, had a population of 110, which was five less, in the correctional department where misdemeanants are sent, and 74, which was five more, in the penal department where women convicted of felonies are confined.

* * *

A total of 1,623 new patients were admitted to the state's eight institutions for mental cases during the last fiscal year, according to John A. Brown, secretary of the Board of State Charities. The largest number of new admissions was at the Evansville State Hospital, at Evansville, where 295 were received. Of these 165 were men and 130 women. This was an increase of six in total admissions as compared with the preceding year. Total admissions for the other institutions, together with the increase or decrease from the preceding year were: Central State Hospital, at Indianapolis, 251 admissions, decrease of 52; Logansport State Hospital, 297, increase of 18; Richmond State Hospital, 169, decrease of 19; Madison State Hospital, 274 admissions, increase of 14; Fort Wayne

State School, 150, increase of 42; Muscatatuck Colony for Feeble-minded Youth, 58 admissions, increase of 42; Village for Epileptics, 129 admissions, decrease of 26.

* * *

A statement of Alfred Hogston, state fire marshal, concerning the actions of pyromaniacs, is an interesting commentary on this peculiar type of psychopathy. Of all the incendiary or arson fires with which the department must deal, approximately six per cent are the work of pyromaniacs, Mr. Hogston said. "These pyromaniacs are usually those that are not otherwise recognized as mentally unbalanced or perverted sexually," Mr. Hogston said. "They are frequently very clever at eluding detection and require a close study of the fires, as to frequency, neighborhood, time and other data, before the culprit can be apprehended. Once detected, it usually proves quite a watch before he can be caught in the deed of starting fires." "However," Mr. Hogston continued, "the pyromaniac usually cannot resist the temptation to stay in the crowd that collects at a fire, and sometimes even claims to have discovered and reported it. After he has once brought himself into the picture, it becomes fairly easy to get an admission of guilt from him."

"THE VOICE OF THE DOCTOR"

MILES F. PORTER, M. D., FORT WAYNE

Another bar has just been added to the "Depression Dirge." I refer to the reports (majority and two minority) of the Committee on the Costs of Medical Care, which have just been born, after a gestation of five years, and the comments thrown by the professional and lay press, together with the final report of the Commission on Medical Education.

As indicated above, the first mentioned commission labored five years while the second one labored seven years.

Perhaps the greatest good that will come to the people and to the profession from these reports and the comments upon them, will come from the fact that they will awaken both the profession and the lay public to the enormous importance to civilization of all questions concerning the prevention and cure of disease.

As the writer sees it, the medical profession is suffering her share in a world dilemma, and in large measure the way out is a common way for all groups. Particular roads will be necessary to meet the exigencies that are peculiar to certain activities of course, but the same end is sought by all—the health and happiness of the people.

The world is educated beyond its social capacity with the result that we have created more than we can consume with the ways and means of distribution as at present. So we have a surplus of food and clothing and people starving and cold; there are more doctors than are necessary and some communities are without doctors. There are more hospitals than are needed and more nurses, and yet with an oversupply of medical help, the costs of medical care are too great. Stagnant wealth, food, clothing, etc., as well as money, is the world's human and economic curse.

The doctor's dilemma today is in large part due to this "curse" and not, as the *Philadelphia Record* says, to the attempt of the profession to "apply a medieval ethical system to the modern world." The fact is that the doctors are suffering now chiefly because of failure in business, including the banks, and yet the editor of the *Record* advises the doctors to accept the usual "system of business ethics."

We can make some changes in the conduct of our business that would be beneficial not only to the doctors but the patients as well, but the Lord help the people when the medical profession is guided by the ethics of business. In the writer's opinion commercialism is the greatest menace confronting the profession of medicine today.

There is nothing in the principles of ethics as adopted by the American Medical Association that prevents a doctor from making a good living and laying up something for a rainy day. On the other hand no man can achieve wealth in the practice of medicine and command the esteem of his confreres.

The reports referred to at the beginning of this article are the result of earnest, honest, long continued study by trained men of experience, and deserve careful study at the hands of all who are interested in human welfare.

D. F. CAMERON, M. D., FORT WAYNE

A few months ago I saw a report that the House of Delegates of the Medical Society of the State of New York at the last meeting on May 23, 1932, had passed the following resolution:

"In that vast majority of families where there is a limit of ability to compensate professional service, if there has been a bona fide participating service and responsibility, then with the knowledge of the patient, the lump sum which is possible should be divided between the participants according to the respective bona fide service rendered by each."

Although the wording of this resolution is poor, there is no doubt about its meaning. It approves this just type of fee splitting or division of fees. So do practically all doctors who have an unimpaired sense of justice.

Likewise, practically all of us will agree thoroughly with the following quotation from the "Principles of Professional Conduct" of the abovenamed society: "Physicians shall not give nor offer . . . directly or indirectly any gift, gratuity, commission, or bonus in consideration of or in re-

turn for the referring . . . of any patient for medical, surgical, or other treatment . . ."

The above quotations are taken from a letter which lies before me written by the assistant secretary of the medical society of the State of New York. Unfortunately, he states that some question has been raised regarding the consistency of these two positions. I believe that practically all right-thinking people approve of the sentiment of these two quotations and see no inconsistency in them.

Chapter XIII of the By-Laws of the Indiana State Medical Association reads as follows:

"This association does not countenance or tolerate fee-splitting, division of fees, or commission paying directly or indirectly, and any member found guilty shall be expelled from membership."

I prefer to believe that the second quotation above from the "Principles of Professional Conduct" states much more accurately what our members actually believe and really prefer to constitute Chapter XIII of our By-Laws.

The suggestion is made that all constituent societies of our association that feel so inclined instruct their delegates and officers to take such action as is necessary to bring about this change.

WILLIAM F. KING, M. D., INDIANAPOLIS

December 15, 1932.

Mr. Harry H. Moore,
The Committee on the Costs of Medical Care,
910 Seventeenth Street,
Washington, D. C.

My Dear Mr. Moore:

I believe the final report and recommendations of the committee are deserving of the widest possible discussion and the fullest possible consideration. There will be differences of opinion, of course, in reference to some of the recommendations and possibly in reference to all of them. Because of this difference of opinion, it should be possible to have these recommendations studied and discussed by professional groups and also by leaders in other groups and organizations interested in public welfare. Out of all this discussion should come a better understanding of the problems involved and better planning to meet medical and public health needs. I believe the first group that should take up this discussion and consideration is the organized medical profession. I also believe that this discussion should begin with the county or district medical societies rather than with the American Medical Association, and that the expression of group opinion should go up from the profession as represented in county and district medical societies to the A. M. A. rather than for opinion to be handed down from the A. M. A. to constituent organizations.

Having this thought in mind, I would suggest that the committee get in touch with the president of the Marion County (Indianapolis) Medical Society, who is Dr. Walter F. Kelly, 5503 East Washington Street, Indianapolis. I believe Dr. Kelly will be anxious to bring this matter before the Indianapolis physicians for a full and frank discussion.

It would be well, I think, also to secure the cooperation of presidents of state medical associations with the end in view of having the report and recommendations of the committee presented to and discussed by county medical societies in every state. I believe firmly that county medical societies are in best position to meet and to solve their own local medical problems because only local physicians can be familiar with local needs and local difficulties in meeting those needs. Being a Presbyterian by inheritance through many generations, I cannot help but believe thoroughly in local government.

It does seem to me that questions of medical policy, as related to medical problems, should be adopted by and applied by those who are nearest to the actual problem.

If your committee plans to have an adequate discussion of the problems brought out by your committee study to the end that a satisfactory solution for meeting these problems may be evolved and adopted, I should recommend that by all means the reports and recommendations of the committee should first be considered by the medical profession itself.

Very truly yours,
WM. F. KING,
Secretary.

R. A. CRAIG, M. D., KOKOMO

Heretofore it has been the policy of this organization to be strictly scientific and devote little of its time to medical economics. This policy conforms with my opinion as to the purpose of a medical society. However, we cannot escape the fact that powerful economic forces are at work and great changes are taking place in our nation, state and county, and that we are vitally interested in them inasmuch as they affect the personal relationship between the physician and his patient. Never in the history of medicine has there been a more determined effort on the part of any selected group to meddle in our affairs.

There is a wide margin between the price the producer gets for his products and that which the consumer pays, in nearly every line except medicine. So the great army of professional "middle men" are casting hungry eyes in our direction. They profess to be able to raise the price for us, the producers lower the cost to the public, the consumer, and undoubtedly profit by handling the business.

The first duty, then, of the society this year should be absolute co-operation in regard to the "Economics of Medicine."

An opinion handed down from the Judicial Council states that "a fundamental of medical ethics is anything which in effect is opposed to the ultimate good of the people at large, is against sound public policy and, therefore, unethical." This decision, if wisely used, will clarify our local situation.

The second suggestion for your approval is that we, as medical men, give our experience to others of our profession.

The third plea is for a concerted booster campaign for our own members. If we must say anything about one of our collegues, let us talk about his good points. It will reflect just credit to all.

(Presented before Howard County Medical Society, January, 1933.)

DIPHTHERIA DEATHS for DECEMBER, 1932, AND TOTAL FOR THE YEAR, 1932

Twenty-four deaths in December and eight delayed reports bring the total for the year to 172, approximately the number of deaths reported in the years 1927 and 1928, and is definitely more than we had in the years 1929, 1930 and 1931. This makes it appear that we are slipping back in our argument with diphtheria. It is, however, in exact accord with the prediction made in this column as long as three years ago. In Indiana diphtheria tends to go in major cycles of about twelve years and minor cycles of about six years. The last major crest was in 1921, with a rate of about 24 deaths per 100,000. The last minor crest was in 1927, with a rate of something slightly over 7. The rate for 1932 is approximately 5.3. This means that 1932 or possibly 1933 is due for a major crest again, and after that we should be able to send diphtheria down to new low levels.

Certain counties are pointed out as having very uncomplimentary rates. The worst of these, by all odds, is Delaware County with 16 deaths. After it comes Allen with 10, and a great number of clinical cases during the entire year. Lake County has 11 deaths. Lawrence, Vigo and Monroe Counties have 7 each. Greene County with 8 deaths will show a high rate. Marion County with 6 deaths will have a rate of about one-fourth of the state average.

Below is given the number of deaths for each county for the year, for the month of December and also the delayed reports.

County	Total for 1932	Delayed Report	December
Allen	10	..	3
Boone	1	..	0
Brown	4	1	1
Clark	3	..	0
Clay	1	..	0
Clinton	2	..	0
Crawford	1	..	0
Daviess	3	..	0
Delaware	16	1	1
Dubois	1	..	0
Fayette	2	..	0
Fountain	2	1	0
Franklin	1	..	0
Gibson	1	..	0
Grant	2	..	0
Greene	8	1	2
Hamilton	3	..	0
Henry	2	..	1
Howard	4	..	0
Huntington	1	..	0
Jackson	5	..	1
Jay	1	..	1
Knox	3	..	0
Lake	11	..	1
Lawrence	7	..	1
Madison	2	..	1
Marion	6	..	2
Martin	1	..	0
Monroe	7	1	1
Montgomery	1	..	0
Morgan	1	..	0
Noble	3	..	1
Orange	1	..	0
Parke	1	..	0
Perry	3	..	0
Pike	3	..	0
Pulaski	1	..	0
Putnam	2	..	0
Randolph	2	..	0
Ripley	3	3	0
Shelby	4	..	1
Spencer	2	..	0
Sullivan	1	..	1
Tippecanoe	4	..	0
Vanderburg	6	..	1
Vermillion	1	..	0
Vigo	7	..	1
Wabash	3	..	1
Warren	1	..	1
Warrick	2	..	0
Washington	2	..	1
Wayne	3	..	0
Wells	1	..	0
White	1	..	0
Whitley	2	..	0
	172	8	24

DEATH NOTES



Courtesy of Indianapolis *News*

ALFRED HENRY, M. D.

ALFRED HENRY, M. D., of Indianapolis, died December 12. Dr. Henry had served as president of the National Tuberculosis Association. Complete obituary notice appeared in the December issue.

YANCEY N. NEW, M. D., of Danville, died in an Indianapolis hospital, December 20, following a short illness. Dr. New graduated from the Kentucky School of Medicine, Louisville, in 1893. He was a member of the Hendricks County Medical Society, the Indiana State Medical Association and the American Medical Association.

JOHN M. WASHBURN, M. D., of Kewanna, died December 27, aged sixty-five years. Dr. Washburn had been in ill health for several years. He was a member of the Fulton County Medical Society, the Indiana State Medical Association and the American Medical Association. Dr. Washburn graduated from the Medical College of Indiana, Indianapolis, in 1895.

T. S. OWEN, M. D., of Elwood, died December 30, following a long illness. Dr. Owen was sixty-three years old. He was a graduate of the Columbus Medical College, Columbus, Ohio, in 1892, and was a member of the Madison County Medical Society, the Indiana State Medical Association and the American Medical Association.

IRWIN W. TREES, M. D., of Indianapolis, died December 30, following a two-months' illness. Dr. Trees was eighty-one years old. After practicing in Shelby County for twenty years Dr. Trees practiced in Indianapolis, in Mt. Comfort and in Greenfield, returning to Indianapolis in 1930. He graduated from the Medical College of Indiana, Indianapolis, in 1880.

JAMES F. KELLEY, M. D., of Salem, died December 28, aged 63 years. Dr. Kelley had served 19 years as coroner of Washington County and was to have begun another term on January 1. He was a member of the Washington County Medical Society, the Indiana State Medical Association and the American Medical Association. He graduated from the Hospital College of Medicine, Louisville, Kentucky, in 1893.

FRANK D. FANNING, M. D., of Butler, died January 16th, aged 59 years. He graduated from the University of Illinois College of Medicine in 1897. Dr. Fanning was a member of the Dekalb County Medical Society, the Indiana State Medical Association and the American Medical Association.

HARVEY WORTH SIGMOND, M. D., of Crawfordsville, died January 3rd, aged 61 years. Dr. Sigmond had been ill since he suffered an injury in an automobile accident several months ago. Dr. Sigmond was a roentgenologist. He was a member of the Montgomery County Medical Society, the Indiana State Medical Association, a Fellow of the American Medical Association, and a member of the Radiological Society of North America. He was a graduate of the Hospital College of Medicine, Louisville, in 1898.

NEWTON ISAAC BRENT, M. D., of Crawfordsville, died January 13th, aged 87 years. Dr. Brent volunteered for service during the World War, and while he was not accepted for service in the regular army, he was assigned to the Soldiers' Home at Lafayette. He retired from active practice in 1920. Dr. Brent graduated from the Hospital College of Medicine, Louisville, in 1875.

J. J. GROSVENOR, M. D., of Richmond, died January 8th, aged 44 years. Dr. Grosvenor had been ill for a period of eight weeks. He had practiced medicine in Richmond for more than twenty years. During the World War Dr. Grosvenor served as a first lieutenant in the medical corps. He graduated from the Indiana University School of Medicine in 1911.

SMITH D. TAYLOR, M. D., of Gary, died December 31st, after an illness of nine months. Dr. Taylor was fifty-four years of age. He was a member of the Lake County Medical Society, the Indiana State Medical Association and a Fellow of the American Medical Association. He graduated from the Louisville Medical College in 1903.

HOOSIER NOTES

Dr. Hugh A. Kuhn, of Hammond, has returned home after an extensive course of study in Europe.

Members of the Carroll County Medical Society enjoyed a turkey dinner December 2.

The Perry County Medical Society met at Tell City, January 11th, for election of officers.

Dr. T. C. Cochran, of Kokomo, has moved from West Walnut Street to 214 East Walnut Street.

Dr. and Mrs. F. E. Radcliffe, of Bourbon, are spending several months in Florida.

Paul K. Cullen, M. D., of Indianapolis, has announced removal of his office to 424 Hume Mansur Building.

Dr. Charles Hupe, of Lafayette, will complete twenty-seven years of service as treasurer for the Tippecanoe County Medical Society this year.

Members of the Owen County Medical Society met with Dr. Boaz Yocum, of Coal City, for the December meeting of the society.

Dr. S. C. Murphy, of Warsaw, has resumed his practice after an absence of several months because of illness.

Dr. Robert A. Smith, of Newcastle, has moved his office from 1205 Race Street to 312 Burr Building.

Miss Wilma Baker, of Indianapolis, and Dr. Frank Newcomer, of Elwood, were married at Hartford City Christmas afternoon.

Dr. Fred Whisler, of Wabash, presented a talk on "Helpful Health Hints" before members of the Muncie Academy of Medicine, December 21.

The Knox County Medical Society held its annual session at Vincennes, December 16. Albert Stump, of Indianapolis, addressed the members.

Dr. A. T. Harris has been employed to direct the new x-ray laboratory of the Indianapolis Methodist Hospital.

Members of the Rush County Medical Society met at Rushville, January 2nd. Dr. J. C. Sexton talked on "Artificial Pneumothorax."

Dr. Grover C. Penberthy, of Detroit, presented a talk on "Osteomyelitis" before the Elkhart County Medical Society, at Elkhart, January 5th.

Officers for the Ripley County Medical Society for 1933 are: Dr. T. M. Brenton, Osgood, president; Dr. Randolph L. Compton, Osgood, secretary-treasurer.

1933 Officers for the Greene County Medical Society are: Dr. G. E. Moses, Worthington, president; Dr. W. F. Craft, Linton, vice-president, and Dr. Carl G. Porter, Jasonville, secretary-treasurer.

C. F. Hope, M. D., of Ellettsville, has been made president of the Monroe County Medical Society, and Ben Ross, M. D., of Bloomington, has been made secretary-treasurer.

Dr. E. Rogers Smith, of Indianapolis, discussed "Psychotherapy" before members of the Kiwanis Club at the Columbia Club, Indianapolis, December 21.

Dr. K. K. Chen, director of pharmacological research at the Eli Lilly Laboratories, presented an illustrated lecture on toad poisons at the Purdue Pharmacy Building, December 5.

Dr. R. A. Flack, of Lafayette, presented a paper on "The Early Diagnosis of Goiter" before the Fountain-Warren County Medical Society, December 1, at Attica.

At the December 16 meeting of the Hendricks County Medical Society, Dr. Henry F. Beckman, of Indianapolis, discussed the management of the first stage of labor. Attendance numbered twelve.

Dr. H. H. Botts has assumed his duties as director of the U. S. Veterans' Hospital at Marion. Dr. Botts was appointed to fill the vacancy caused by the death of Colonel William MacLake.

THE last 1932 meeting of the Gibson County Medical Society was held December 12 at Princeton. Dr. H. C. Ruddick, of Evansville, presented a paper on "Hand Infections."

DR. LUTHER WILLIAMS discussed "Breast Tumors" at the January 10th meeting of the Hamilton County Medical Society, which was held at Noblesville.

OFFICERS for the Pike County Medical Society have been elected as follows: President, T. R. Rice, M. D., Petersburg; secretary-treasurer, A. R. Logan, M. D., Petersburg; delegate to the state convention, George De Tar, M. D., Winslow.

THE University of Michigan Medical School and the Michigan State Medical Society have announced postgraduate courses for 1933. Complete schedule appears on advertising page xii in this issue.

"THE PRACTICAL CARE OF DIABETICS" was the subject of a paper presented by Dr. John Warvel, of Indianapolis, at the January 4 meeting of the Wabash County Medical Society at North Manchester.

DR. JOHN LANSFORD, of Redkey, is the new president of the Jay County Medical Society. Dr. F. E. Keeling, of Portland, was elected vice-president, and Dr. B. M. Taylor, of Portland, was re-elected secretary-treasurer for the fifth consecutive time.

DR. C. NORMAN HOWARD, Warsaw, has been made president, Dr. Russell E. Phillips, Warsaw, secretary-treasurer, and Drs. O. H. Richer and A. C. McDonald, members of the Legislative Committee, of the Kosciusko County Medical Society for 1933.

ANNUAL election of officers for the Daviess-Martin County Medical Society, December 27, resulted as follows: President, Dr. Maude Arthur, Washington; vice-president, Dr. J. H. DeMotte, Odon; secretary, Dr. E. B. Smoot, Washington.

DR. H. B. METTEL, of Indianapolis, was made president of the American Business Club by the Board of Directors. Other officers are Judge John W. Kern, vice-president, and Ralph Thompson, secretary.

IN addition to the articles already enumerated the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

Maltine Company

Maltine with Mineral Oil and Cascara Sagrada

THE annual meeting of the St. Joseph County Medical Society was held at South Bend, December 6. Officers were elected as follows: President, Dr. H. J. Graham, Mishawaka; vice-president, Dr. Milo K. Miller, South Bend; secretary-treasurer, Dr. R. B. Dugdale, South Bend; assistant secretary-treasurer, Dr. Martha B. Lyon, South Bend.

THE Terre Haute Academy of Medicine held a banquet at the Hotel Deming, December 9. Officers of the Vigo County Medical Society, the Fifth District Medical Society and the Wabash Valley Aesculapian Society were present. H. J. Anslinger, of Washington, D. C., commissioner of narcotics, presented the principal address.

THE Sullivan County Medical Society held its January 4th meeting at the Mary Sherman Hospital, Sullivan, Indiana. Dr. J. R. Crowder presented an interesting report of a gunshot wound of the abdomen, in which the bullet passed between the mesenteric folds posteriorly and made only one hole in the colon.

DR. MARK M. LORING, of Chicago, was the speaker at the December 15th meeting of the LaPorte County Medical Society. Officers were elected for 1933 as follows: President, Dr. J. R. Phillips, Michigan City; vice-president, Dr. J. H. Fargher, LaPorte; secretary-treasurer, Dr. E. E. Linn, LaPorte.

A MEETING of the Orange County Medical Society was held at the home of Dr. George Dillinger, of French Lick, December 14. Following a dinner the annual election of officers was held. Dr. C. E. Boyd, of West Baden, was made president; Dr. H. L. Miller, West Baden, vice-president, and Dr. George Dillinger, of French Lick, re-elected secretary-treasurer.

MEMBERS of the Vigo County Medical Society met at Terre Haute, December 13. Dr. O. T. Allen, of Terre Haute, presented a case of carcinoma of the throat. Officers of the society for 1933 were elected: Dr. George C. Congleton, Terre Haute, president; Dr. C. A. Curry, vice-president, and Dr. A. M. Mitchell, Terre Haute, secretary-treasurer.

MEMBERS of the Gibson County Medical Society met at Wheeler's Cafeteria, Princeton, January 9th. Dr. Paul D. Crimm, of South Bend, presented a paper on "Early Evidences of Tuberculosis in Children." Attendance numbered twenty-four. The Gibson County Medical Society will entertain the First District Medical Society at Princeton, May 18, 1933.

MEMBERS of the Montgomery County Medical Society met at the Culver Hospital, December 29. Mr. Albert Stump, attorney for the Indiana State Medical Association, presented an interesting address on "Medical Care of the Poor." Officers for 1933 were elected as follows: President, Dr. Robert Pollom, Darlington; vice-president, Dr. A. L. Loop, Crawfordsville; secretary-treasurer, Dr. George A. Collett, Crawfordsville.

DR. MAX BAHR, retiring president of the Indianapolis Medical Society, was given a certificate of service at the annual meeting of the society held January 3. Officers for 1933 are: Dr. Walter F. Kelly, president; Dr. J. O. Ritchey, first vice-president; Dr. John M. Whitehead, second vice-president, and Dr. James S. McBride, secretary-treasurer. A reception and dancing followed the dinner meeting.

A BOARD OF CERTIFICATION for specialists in anesthesia was formed at the recent Congress of Anesthetists in New York. The board is empowered to draw up requirements for specialization in anesthesia and will make a survey of anesthetists, which will be submitted as a register of accredited specialists in this field. At this congress Dr. Arno B. Luckhardt, of Chicago, was elected president of the International Anesthesia Research Society.

DR. JOHN THOMSON, of Garrett, was elected president of the Northeastern Indiana Academy of Medicine at the meeting held in Kendallville, December 22. Dr. P. N. Sutherland, of Angola, was made vice-president, and Dr. Frank Black, of Ligonier, secretary-treasurer. Dr. C. E. Munk, of Kendallville, was re-elected chairman of the Program Committee, which appointment he has held for the past nine years. Dr. B. S. Cornell, of Fort Wayne, presented the principal address.

FROM February 12 to 25, 1933, there will be a training period for medical department reserve officers of the Army and Navy, made possible at the University of Washington Medical School, St. Louis, Missouri, by the courtesy and enthusiasm of the faculty of this school in co-operation with the medical department of the Army and Navy. Applications for attendance should be forwarded to the Surgeon, Seventh Corps Area, Omaha, Nebraska.

THE Indiana Academy of Ophthalmology and Otolaryngology held its sixteenth annual meeting in South Bend, December 16. Speakers were Dr. J. R. Gillum, Terre Haute, president of the Academy; Dr. C. J. Adams, Kokomo; Dr. H. S. Kuhn, Hammond; Dr. O. G. Brubaker, North Manchester; Drs. S. S. Aronson, B. J. Larkin, D. O. Kearby, J. W. Carmack, D. H. Rowe and W. F. Hughes, all of Indianapolis, and H. L. Brooks, of Michigan City.

DO YOU KNOW that the Indiana State Medical Association will supply you with blank forms for your accident patients to sign? By having your accident patient sign this form, he agrees to be responsible for the bill, and authorizes you to accept payment direct from the insurance company. He also gives permission for you to give to any person, firm or corporation such information as to physical condition of the patient as may be necessary, and permits you to testify as a witness, if called upon to do so. A few moments spent in having this blank completed may save you hours of work a little later. Send for a supply today. Write to the Indiana State Medical Association, 1021 Hume Mansur Bldg., Indianapolis, Indiana, and ask for "Accident Insurance Blanks."

MEMBERS of the Porter County Medical Society met at the Hotel Lempke, at Valparaiso, December 26. G. G. Campbell, M. D., of Wheeler, presented a paper and moving pictures describing his experiences while a medical officer in the British government service in Borneo. Society officers elected for 1933 were: President, Dr. F. J. Kleinman, Hebron; vice-president, H. M. Evans, M. D., Valparaiso; secretary-treasurer, J. C. Brown, M. D., Valparaiso; censors, E. H. Miller, M. D., Valparaiso, and J. W. Dale, M. D., Chesterton.

THE American Board of Obstetrics and Gynecology has announced that the next written examination and review of case histories will be held in cities throughout the United States and Canada, on April 1, 1933. The next general clinical examination is to be held in Milwaukee, June 13, 1933, immediately preceding the annual session of the American Medical Association. Reduced railroad rates will apply. Further information may be obtained from the Secretary, Dr. Paul Titus, 1015 Highland Building, Pittsburgh, Pennsylvania.

THE Madison County Medical Society held its annual business meeting and election of officers December 19. Dr. George B. Metcalf, Anderson, was named president; Dr. A. J. Fitzpatrick, of Elwood, vice-president, and Dr. Sam Litzenberger, Anderson, secretary-treasurer. The report of the Committee on Costs of Medical Care was read to the members, and Dr. M. A. Austin, of Anderson,

presented a paper on "State Medicine." Dr. Herman Morgan, of Indianapolis, and Dr. Frank Cregor, of Indianapolis, presented papers.

DR. A. W. CAVINS, of Terre Haute, has been engaged as full time physician for the Rose Free Dispensary, of Terre Haute, beginning February 1, 1933. The Dispensary furnishes out-patient treatment and medicines to the worthy poor of Vigo County. The staff will consist of Dr. Cavins, an attending dental surgeon, an eye, ear, nose and throat physician and a graduate nurse. The work of the dispensary is under the control of a board of medical advisors consisting of Drs. O. O. Alexander, A. M. Mitchell, C. N. Combs, O. R. Spigler and E. C. McBride.

DR. JOHN F. BARNHILL, of Indianapolis, Indiana, and Miami, Florida, will present a postgraduate course in surgery of the head and neck, for the Research Study Club of Los Angeles, from January 16th to January 27th. Dr. John E. Weeks, Dr. Joseph C. Beck, Dr. Bernard Samuels, Dr. Sanford R. Gifford, and Dr. Joseph L. McCool will also give courses in otolaryngology and ophthalmology at this postgraduate school which is one of the most important in the country. In April Dr. Barnhill will give this course at the Indiana University School of Medicine.

DR. A. L. SPINNING, Covington, talked about "Pioneer Physicians of Fountain County, Indiana" and a symposium on "Medical Care of the Poor" was presented before the members of the Fountain-Warren County Medical Society, at Hillsboro, January 5th. Dr. Spinning mentioned that Dr. John Evans, of Fountain County, sponsored bills to establish a school for the blind and a school for mutes. He also founded Evanston City, and Evanston University, in Illinois. Mt. Evans, in Colorado, is named in honor of Dr. Evans. Dr. George Rowland, of Covington, sponsored the first bill, in 1888, to have college-trained physicians registered

THE Northern Tri-State Medical Association will holds its sixtieth annual meeting at Laporte, Indiana, April 11, 1933. Speakers will be Dr. Henry A. Christian, of Harvard; Dr. Plinn Morse, of Harper Hospital, Detroit; Dr. Charles P. Emerson, of Indiana University; Dr. Charles Lukens, of Toledo, Ohio, and others. Complete programs will be available early in February. Officers of the association are Edward B. Pedlow, M. D., president, Lima, Ohio; G. O. Larson, M. D., vice-president, Laporte, Indiana; Edward P. Gillette, M. D., secretary, Toledo, Ohio, and H. E. Randall, M. D., treasurer, Flint, Michigan.

THE annual congress on Medical Education, Licensure and Hospitals (composed of the Council on Medical Education and Hospitals of the A. M. A., the Association of American Medical Colleges, Federation of State Medical Board of the U. S., The American Hospital Association, will be held at the Palmer House, Chicago, February 13 and 14, 1933. Problems to be discussed at this meeting are contract practice, regulation of specialists, enforcement of practice act, and what shall be done with 1,500 American students, soon to be graduated from European medical colleges returning to the United States for licensure and practice.

THE Indiana University School of Medicine has announced a new course in medical economics and medical ethics to be given to the senior class. The purposes and content of this course have been approved by the Indiana State Medical Association, which has appointed a committee, composed of Dr. George J. Geisler, of South Bend, Dr. Cyrus Clark, of Indianapolis, and Dr. G. D. Scott, of Sullivan, to co-operate with the faculty of the medical school in giving the course. Members of the Indiana State Medical Association are invited to attend the lectures, which will be as follows:

1. General Principles of Ethics—Mr. Daniel S. Robinson, Dept. of Philosophy, Indiana University.
2. Principles of Medical Ethics — Dr. J. M. Barry.
3. Work and Ideals of Organized Medicine—Dr. Joseph Weinstein.
4. Newer Forms of Medical Practice—Dr. Olin West, Chicago.
5. Duties of the Doctors in Safeguarding Public Health—Dr. Thurman B. Rice.
6. Conduct of Consultations—Dr. William N. Wishard, Sr.
7. Prognosis—Dr. J. Oscar Ritchey.
8. Code of Medical Ethics—Dr. W. D. Gatch.
9. Problems of the Young Physician — Dr. Cyrus Clark.
10. Saving and Safe Investment — Mr. Evans Woollen, Jr.
11. The Mathematics of Life Insurance—Mr. Charles Beckett.
12. Life Insurance Examinations—Speaker to be announced.
13. The Office Equipment of the Doctor—Dr. Carl McCaskey.
14. The Work of the Indiana State Board of Medical Registration and Examination—Dr. William R. Davidson.

This course of lectures will begin at 1:00 o'clock on Wednesday, February 1, and thereafter the classes will meet regularly each week on Wednesday at 1:00 o'clock. There will be no charge to members of the Indiana State Medical Association who attend.

SOCIETIES AND INSTITUTIONS

INDIANA STATE MEDICAL ASSOCIATION BUREAU OF PUBLICITY

November 28, 1932.

Meeting called to order at 3:30 p. m.

Present: William N. Wishard, M. D., chairman; J. H. Stygall, M. D.; E. D. Clark, M. D., and T. A. Hendricks, executive secretary.

Release for publication in Saturday afternoon papers, December 17, "Campaign Against Appendicitis," read and approved.

Radio release, Saturday, November 26, "Laxatives and Appendicitis."

Representative of the American Society for the Control of Cancer asked to appear at the annual midwinter meeting of the Council on Thursday, December 1.

The following letter was received from the director of a commercial laboratory:

"Pursuant to the informal meeting with the members of your committee a few days ago relative to offering the services of the physicians comprising our Medical Research Department to serve on programs before the various county medical societies, I beg to submit the following in compliance with your request:

"Realizing that your bureau is oftentimes confronted with the problem of supplying speakers for medical meetings, I wish to offer the services of the various physicians comprising our Department of Medical Research who are qualified to fill such vacancies on programs. In so doing we assure your bureau that such talks will be of a scientific, informative and non-commercial nature, and that each speaker will be cognizant of the fact that in the acceptance of such invitations he is a representative of the Bureau of Publicity of the Indiana State Medical Association and will at all times adhere to the ethical policies advocated by this bureau.

"Should this offer meet with favorable acceptance, we would be pleased to submit a list of topics upon various medical and biological subjects from which a choice could be made, which would suitably adapt itself to the program in question."

The secretary was instructed to write the director asking him to submit topics.

Letter received from the secretary of the Ripley County Medical Society in regard to the diphtheria immunization campaign carried on in that county. The bureau instructed the secretary to acknowledge this letter and state that it would be interested in seeing the final report.

A short review of "The Indian Guide to Health for the Cures of All Disorders Incident to This Climate," by Dr. S. H. Selman of Columbus, Indiana, published in 1836, was presented to the Bureau by one of the members assigned to this duty.

Report upon "Preliminary Draft of Fifth Tentative Draft of an Act Concerning the Control of Narcotic Drugs" was made at the request of the Bureau of Legal Medicine and Legislation of the American Medical Association. The secretary was instructed to write a letter to the director of the Bureau of Legal Medicine and Legislation giving the suggestions of the Bureau in regard to this proposed legislation.

The above minutes were approved in each separate part and as a whole December 23, 1932.

BUREAU OF PUBLICITY

December 23, 1932.

Meeting called to order at 3:00 p. m.

Present: William N. Wishard, M. D., chairman; J. H. Stygall, M. D.; E. D. Clark, M. D., and T. A. Hendricks, executive secretary.

Release for publication in Sunday morning papers, January 1, 1933, "Health Resolutions," read and approved.

Radio releases:

Saturday, December 3, "A Campaign Against Appendicitis."

Saturday, December 10, "The History of Influenza."

Saturday, December 17, "The Common Cold."

Requests for speakers:

December 14, 1932, Ripley County Medical Society, Osgood, Ind.—"The Legal Aspect of Poor Relief." Speaker obtained.

December 16, 1932, Knox County Medical Society, Vincennes, Ind. Speaker obtained.

January 5, 1933, Clinton County Medical Society, Frankfort, Ind. Speaker on "Medical Economics" obtained.

January 12, 1933, Hancock County Medical Society, Greenfield, Ind. Dentists will meet with physicians. Speaker on "State Medicine" obtained.

Continuing the correspondence referred to in the minutes of November 28, a letter was received from the director of a commercial laboratory in answer to a request that a list of topics that might be covered by speakers from this laboratory be submitted to the bureau. The subjects mentioned were:

1. Recent Progress in Medical Research.
2. Modern Viewpoints Concerning the Treatment of Anemias.
3. Treatment of Diabetes.
4. Diabetes—The Management of Surgical Complications with Special Reference to Diseases of the Extremities.
5. Barbituric Acid Medication in General and Special Practice.

The secretary was instructed by the bureau to answer the letter, stressing the points that these talks should be made before professional audiences only, and that under no circumstances should the commercial connection of the speaker be mentioned.

The bureau was informed that the Editorial Board at its meeting of November 30 suggested that the Bureau of Publicity minutes, printed in THE JOURNAL, be abstracted fifty per cent. The bureau instructed the secretary to comply with this suggestion.

The following letter was received by the bureau from the director of the Division of Public Health Nursing of the Indiana State Board of Health:

"The work of the Division of Public Health Nursing, Indiana State Board of Health, is based on the principle of indirect service to communities in the state, that is, we try to teach the public health nurses locally employed in towns and rural sections to do better work with all age groups—especially in the following phases of their activities: prenatal, infant and child welfare, school health, tuberculosis, communicable disease, etc. Three main ways in which we do this are:

1. *Advisory visits in the field*, which most of the public health nurses consider most helpful of all.
2. *"Echoes"*—the bulletin published by the department.
3. *Regional Institutes*—held in different localities over the state where public health nurses can meet and discuss their problems.

"It is in regard to the last named method of staff education that this communication is sent to the Bureau of Publicity of the State Medical Association.

"We are planning a public health nurses' institute for the region around Kendallville for January 14. Public health nurses from St. Joseph, Elkhart, LaGrange, Noble, DeKalb, Kosciusko, Allen and Jay counties will attend. Public health nursing board and committee members and teachers will also be invited. The idea is to have the people *actually doing the work* be the chief participants in the program. We are doing our best to teach the nurses to constantly seek the advice and guidance of the physicians individually and collectively in their work and we feel this program would not be complete without a representative of the medical profession on it.

"What we wish to ask the committee of the Indiana State Medical Association is:

1. Would the medical councilor in this district feel it worth his while to address this meeting? (No expenses can be paid.)
2. What topic should be assigned him?
3. Is his place on the program satisfactory?
4. Are there any suggestions as to how any other part of the program can be improved?

"In February we hope to hold similar regional meetings in Delphi and Newcastle—and with medical councilors of these respective districts on the program. Is this plan satisfactory to the medical committee?"

The questions were answered as follows by the bureau in a letter of December 9:

1. Yes.
2. "The Doctor and the Public Health Nurse."

3. Yes, if his appointment is approved by local district medical society officers.
4. By constant emphasis of intelligence and harmonious co-operation between the public health nurse and the medical profession, and careful avoidance of any sort of prescribing without prior approval of physician in charge.

A copy of the proposed survey of maternity and infancy service in Indiana counties was presented to the bureau by the director of the Division of Infant and Child Hygiene of the Indiana State Board of Health. The bureau instructed the secretary to acknowledge the receipt of this and to write the director stating that the bureau had serious doubts as to the advisability of such a survey.

The above minutes were approved in each separate part and as a whole January 5, 1933.

BUREAU OF PUBLICITY

January 5, 1933

Present: William N. Wishard, M. D., chairman; J. H. Stygall, M. D.; E. D. Clark, M. D.; J. H. Weinstein, M. D., president, and T. A. Hendricks, executive secretary.

Radio releases:

Saturday, December 24—"Holiday Health."
Saturday, December 31—"Health Resolutions."

Request for speaker:

January 12, 1933—Kiwanis Club, Bluffton, Indiana. Speaker desired to talk on "The Sanitary Production of Milk, etc." Request referred to the secretary of the Indiana State Board of Health.

Continuing the correspondence referred to in the minutes of November 28 and December 23, the following letter was received from the director of a commercial laboratory in answer to a letter from the Bureau of Publicity:

> "I am very pleased at the action of the Bureau of Publicity and wish to assure them through you that we will comply with the two rules set forth in your letter, namely:
>
> (1) The talks will be made before professional audiences only, and
> (2) Under no circumstances will the commercial relationship of the speaker be mentioned."

Letter received from the secretary of the American Medical Association in answer to a request of the Bureau for information in regard to the report of the Commission on Medical Education. From the newspaper reports on this report the Bureau understands that it contradicts the majority report of the Committee on the Costs of Medical Care and that it specifically is opposed to any movement to socialize medicine. The letter follows:

> "The Commission on Medical Education, of which Dr. Lowell of Harvard University is chairman, has recently completed and distributed its final report. This report can be secured through Dr. W. C. Rappleye, Dean of the Medical School of Columbia University, 630 West 168th Street, New York City.
>
> "You may be interested to know that Dr. Wilbur, Dr. Darrach and I were members of the Commission on Medical Education and that we were all members, too, of the Committee on the Costs of Medical Care. Dr. Wilbur and Dr. Darrach signed the majority report of the Committee on the Costs of Medical Care and, in so far as I know, offered no protest concerning the findings of the Commission on Medical Education which definitely opposes the socialization of medicine."

The secretary was instructed to obtain a copy of this report. He also was instructed to send a marked copy of the editorial in regard to the minority report of the Committee on the Costs of Medical Care which appeared in the January Journal of the Indiana State Medical Association to Ray Lyman Wilbur, M. D., chairman, and William Darrach, M. D., who signed the majority report of the Committee on the Costs of Medical Care; also to Harry H. Moore, director of study of the Committee on the Costs of Medical Care, and to the editor of THE JOURNAL of the American Medical Association.

The following letter in regard to the suggestions of the Bureau concerning the uniform narcotic drug act which has been proposed was received from the director of the Bureau of Legal Medicine and Legislation of the American Medical Association:

> "On my recent return to Chicago, I found awaiting me your letter of December 5, relative to the Preliminary Draft of Fifth Tentative Draft of An Act Concerning the Control of Narcotic Drugs. The suggestions embodied in it came too late, however, for consideration by the National Conference of Commissioners on Uniform State Laws. The National Conference of Commissioners on Uniform State Laws approved the draft of a Uniform Narcotic Drug Act on October 8, last, and it was approved by the American Bar Association on October 12. A copy of the approved act has been sent to you.
>
> "So far as I can discover, there is nothing in the Uniform Narcotic Drug Act drafted by the National Conference of Commissioners on Uniform State Laws that interferes in any way with the scientific judgment of the medical practitioner concerning matters relating to the relief, care, and treatment of patients. Section 8, subsection 2, paragraph (a), does not limit the discretion of a physician, dentist, or veterinarian in the prescribing, dispensing, or administering of the narcotic drugs covered by the act. It does limit the discretion of the apothecary, but it is believed that the discretion of the apothecary with respect to the dispensing of narcotic drugs should be limited by the prescriptions that he receives from physicians, dentists, and veterinarians, and by the statute itself. Under the provisions of the law just referred to, a physician can prescribe, administer, or dispense any of the so-called exempted preparations up to the quantities stated, *without formality or record.* He can prescribe, administer, or dispense any quantity whatsoever that may be necessary for the proper treatment of a patient, provided only he complies with the provision laid down in the law in relation to prescribing, administering, and dispensing generally.
>
> "Your comments concerning record-keeping are apt. Obviously, however, some records must be kept, if the abuse of narcotic drugs is to be prevented. When you call to mind the number of physicians, dentists, and veterinarians in the United States, and particularly when you recall the number of them who are outside of the pale of organized medicine, dentistry, and veterinary practice, you will realize the opportunities for abuse of the prescribing, administering, and dispensing of narcotic drugs if no records need be kept. During the several years during which copies of this proposed legislation have been distributed by me, I have looked in vain for any constructive suggestions as to how best to reduce record-keeping to a minimum, without jeopardizing the entire matter of safe-guarding the use of narcotic drugs. In the absence of any such suggestions, I procured the insertion in the Uniform Narcotic Drug Act as adopted by the National Conference of Commissioners of Uniform State Laws, of a provision (Section 9, subsection (1)) whereby no records need be kept by physicians, dentists, and veterinarians, when the amount administered, dispensed, or professionally used in the treatment of a patient does not exceed a certain amount. This will go some way toward meeting the criticism you offer.
>
> "Personally, I cannot see anything unreasonable in requiring physicians, dentists, and veterinarians to keep records of the names and addresses of persons to whom or for whose use narcotic drugs are administered, dispensed, or prescribed. Without the names and addresses of such persons supervision and control of the distribution of narcotic drugs would be impossible. The keeping of such records does not disclose the nature of the ailment from which the patient is suffering, and the legitimate use of narcotic drugs under medical, dental, or veterinary guidance certainly involves no discredit or disgrace.
>
> "I realize, of course, that compliance with such a law as is now proposed will add something to the ordinary duties of physicians, dentists, and veterinarians, but in my judgment it will add little or nothing to what is already required of them under the Harrison Narcotic Act. To the extent, however, to which added labor is required, the physician is at liberty to require his patient to compensate him for that labor, by increasing his charges for professional services.
>
> "I sincerely hope that the act as adopted by the National Conference of Commissioners on Uniform State Laws and approved by the American Bar Association may have the approval of the Indiana State Medical Association. If it fails to win that approval in any way, I hope very much that you will let me have a statement of the exact changes in phraseology that you would suggest."

Pamphlet entitled, "White House Conference Happenings," received by the Bureau.

"Echoes," the publication of the Division of Public Health Nursing of the Indiana State Board of Health, received by the Bureau of Publicity.

A letter was received from the historian of the State Association reporting his work to the present time and outlining plans for future work.

INDIANA STATE BOARD OF HEALTH

DIVISION OF COMMUNICABLE DISEASES

Current prevalence of the more common reportable diseases as indicated by the reports of health officers, physicians and institutions of the state, as compared with the previous month, show an increase. There were 7,412 cases of disease reported, 1,865 cases the previous month and 2,273 cases the corresponding month of the preceding year. The high prevalency is due to the epidemic of influenza.

Influenza. The incidence of the prevalence of influenza shows a widespread epidemic of the disease over the state. There were 5,118 cases reported, 194 last month and 71 cases the corresponding month of the previous year. This report does not indicate the number of cases in the state. There are many thousands of cases not reported. The larger cities of the state do not report their cases. The disease is comparable numerically to December, 1928, when 7,502 cases were reported.

Scarlet Fever. The season's increase is noted in scarlet fever—571 cases reported. There were 479 cases the previous month and 406 cases the corresponding month of the preceding year. The normal average for December over a period of seven years is 585 cases.

Diphtheria. The incidence of the prevalence of diphtheria (388 cases) shows an increase as compared with the previous month, when 347 cases were reported. The estimated expectancy was 232 cases. The estimate is based on the experience of the last seven years.

Typhoid Fever. A slight decline is noted in typhoid fever. Twenty-three cases were reported the current month, 25 cases the previous month and 29 cases in December of last year. This reflects the season's average, which is 23 cases. The estimate is based on the experience of the last seven years.

Smallpox. The smallpox incidence (29 cases) shows a marked increase as compared with the previous month, when eleven cases were reported. The disease has maintained a low level during the year. The average for December covering the period of the last seven years is 326 cases.

Meningococcus Meningitis. The reported incidence (14 cases) of meningococcus meningitis is favorable. Twelve cases were reported last month. Marion County reports 10 of the 14 cases. Thirty-nine cases were reported in December of last year.

H. W. McKANE, M. D.,
Collaborating Epidemiologist,
Indiana State Board of Health,
U. S. P. H. Service.

CLINTON COUNTY MEDICAL SOCIETY

The Clinton County Medical Society met at the Coulter Hotel, Thursday evening, January 5, 1933.

Thirty-seven members and guests were present, all members of the medical profession. Among those who attended were Dr. J. H. Weinstein, president of our State Association; Dr. E. E. Padgett, president-elect of our State Association; Dr. F. T. Romberger, Fifth District Councilor; Past Presidents George R. Daniels and F. S. Crockett; Dr. C. M. Kennedy, president Eleventh District; and presidents of county societies as follows: Dr. Eva Kennedy, Carroll County; Dr. G. A. Thomas, Tippecanoe County; Dr. R. A. Craig, Howard County; Dr. J. S. Ketcham, Clinton County. Also present was Thomas A. Hendricks, executive secretary of the Indiana State Medical Association.

This meeting was devoted to a discussion of medical economics. The importance of this subject was attested by the number of men present and the counties represented. Dr. George R. Daniels discussed the subject from the standpoint of the general practitioner; Dr. J. H. Weinstein considered the standpoint of the clinic; and Drs. R. A. Craig, and H. M. Rhorer, discussed poor relief as practiced in Howard County.

The subjects were well presented and extensively discussed by the members present. It was the consensus of opinion that something must be done from within the profession or something will be done from without the profession.

Everyone present realized that this is one of the greatest problems that ever has confronted the medical profession, and that it is so urgent that it will require settlement in the near future.

At the close of the discussion of medical economics Mr. Hendricks told us of the doings of the present legislature.

Respectfully submitted,
IVAN E. CARLYLE, M. D., Secretary.

LAKE COUNTY MEDICAL SOCIETY

ANNUAL REPORT OF THE EDUCATIONAL COMMITTEE

The Educational Committee of the Society wishes to express its appreciation to the following organizations, who through their officers have rendered valuable assistance in offering suggestions and furnishing material for the carrying out of its campaign of education:

American Medical Association
Indiana State Medical Association
Illinois State Medical Association
Toledo Academy of Medicine

The activities of the committee were confined under four general headings, viz.: Speakers' Bureau, Radio Talks, Press Service, General. The greatest stress was laid upon the institution of radio programs.

Speakers' Bureau

An invitation was extended to one hundred (100) civic organizations in Lake County to call upon us for speakers for their various meetings. These organizations included:

Chambers of Commerce, Noonday Luncheon Clubs, Women's Clubs, Nurses Associations, Boy and Girl Scouts, American Red Cross, Merchants Associations, City Councils, Boards of Works, Boards of Education, Union Associations, Manufacturers' Associations, Trades Associations, Ministerial Unions, Parent-Teacher Councils and Associations, Park Boards, Welfare Associations, Ward Civic Associations, Open Forums, Real Estate Boards, Shrine Clubs and Fraternal Bodies, Booster Associations, Home Owner Associations, American Legion Posts, Veterans of the Foreign Wars Posts, Better Government Clubs, Business and Professional Women's Clubs and miscellaneous lay organizations.

Many replies were received acknowledging the invitation or accepting it.

During the year twenty-eight (28) speakers were furnished for meetings of these bodies.

An outside speaker, Dr. H. S. Hulbert of Chicago, was used on two occasions, where the subject requested was on the topic of "Mental Hygiene and Nursing."

Radio Talks

During the year two radio broadcasting stations were used, WWAE in Hammond and WJKS in Gary.

The material used was that supplied by the American Medical Association.

During the year one hundred and eighty-five (185) radio talks were delivered by the members of the society, one hundred (100) in Gary, eighty-five (85) in Hammond.

Press Service

Very little activity was pursued under this heading. Eight (8) newspaper items were furnished, two (2) in Gary, six (6) in Hammond.

General

Information concerning our campaign and methods was furnished the South Bend Medical Society upon its request to

the State Association. No public health meetings under the auspices of the society were held.

Conclusions

1. The Speakers' Bureau is a valuable adjunct to the society and gives the members opportunity to accustom themselves to addressing public audiences as well as reflecting to the general good of the society, where their talks are definitely announced as coming under the auspices of the society.

We feel that this field has been neglected and urge the greater use of this opportunity to meet the public, and we ask that the members co-operate in making use of every available chance to speak before lay audiences.

2. The radio talks were limited to five minutes each, and were given three days a week. The material furnished by the American Medical Association, we feel, is inadequate. Many of the subjects were so elementary as to be of little value, and in fact to reflect upon the intelligence of the society in presenting them.

We suggest that if this phase is to be carried on, that articles should be prepared by the local members themselves, censored, and that these be upon subjects of live local interest, such as precautionary measures used in combating prevalent epidemics, the accepted medical opinion concerning certain common ailments, the history or romance of medicine, etc.

The response to the radio broadcasts was not encouraging. An invitation at each broadcast was extended to the public to write in their requests for certain topics they might care to hear discussed, in order to secure an estimate as to the possible number listening in, and the interest created. No requests were received, and while numerous people spoke to their physicians about the broadcasts and mentioned having heard them, there were no letters of comment received.

It is believed that some newspaper publicity should precede the broadcasts and that their number should be reduced, and that they should have the preparation of the man who is to deliver them. Fifteen-minute talks in our opinion would be of more value than the five-minute ones.

3. Press service, we feel, has been neglected. It is our belief that more can be accomplished through this medium than through any of the others. The spoken word is evanescent, the written word is permanent, and we feel that our radio talks have failed in making a lasting impression. Certainly much of the material available and stored in the minds of our members is worthy of perpetuation, and we should like to see many newspaper items prepared by the members, censored, and printed in the local press, under the auspices and direction of the society. It is felt that much could be done to dispel distaste for the medical profession in the minds of many of the laity, through the adoption of an active campaign along this line.

4. The general activities of this committee could be broadened in the furnishing to schools, clubs, and other organizations, of suitable poster exhibits, presentation of suitable lay motion pictures secured on loan, holding of lay public health meetings, etc.

A suggestion is advanced that the society provide a suitable prize for the best essay presented on some health topic, by high school students. Any other form of contest which might aid in making the people health conscious should prove of value.

The committee wishes to extend to the membership of the society its appreciation for the excellent co-operation given during the year in the initiation of this program.

Signed:

N. K. FORSTER, Chairman
T. W. OBERLIN,
H. M. BAITINGER,

January 12, 1933.

The Lake County Medical Society met in regular session at Gary Methodist Hospital, Thursday, January 12, 1933.

The minutes of the December meeting were read and approved.

Ballot was had on application of Dr. L. V. Gorilla, of Hammond, resulting in his election.

At the order of the Council, the secretary presented a report re the matter of delinquencies for 1932, the Council having voted to request the various hospitals to enforce staff membership requirements in this connection. Dr. E. D. Skeen arose to enquire why our local dues might not be lowered in these times of economic stress. Several reasons were advanced by various members and Dr. Skeen announced that his question had been fully answered.

Dr. J. A. Teegarden, President-Elect for 1934, who was unavoidably detained from our annual meeting, was informally introduced.

The recent death of Dr. Smith Davis Taylor, of Gary, was announced, and the secretary instructed to dedicate a page in our minutes to his memory. Dr. Jones asked the membership to stand for a moment in memory of Dr. Taylor.

Program:

"Special Methods of X-Ray Examinations".....A. T. Harris
"Septic Abortion".....J. R. Doty
"Treatment of Diabetes".....H. M. English

The discussion of each of these papers was very general, more than the usual number of members taking part. It was universally conceded that this was one of the best programs we have had for some time and demonstrated that our "home folks" can and do perform in a most admirable manner.

Adjourned.

E. S. JONES, President
E. M. SHANKLIN, Secretary

ST. JOSEPH COUNTY MEDICAL SOCIETY

The St. Joseph County Medical Society held its first meeting of 1933, January 4, at 8 p. m., in the Coquillard Club with 50 members and one guest present.

The retiring president, Doctor Boone, called the meeting to order and introduced the new president, Doctor H. J. Graham, of Mishawaka, who gave the following short address:

"Our retiring President and members of the St. Joseph County Medical Society: I would like first to thank all of you for the honor you have bestowed upon me when you elected me president of this organization. My hope is that when the year rolls by, you will have no reason to regret your action and that the year 1933 will be one of happiness, prosperity and achievement. While we are here for a social time and the cultivation of the fellowship of this society, I do not believe that a few serious thoughts would be out of the way. I say this because the conditions brought on by the economic depression cause us to play an important part in the health of the community in the following year. I believe the St. Joseph County Medical Society will have a more vital function to perform, will be in the lime light more often—will have a greater responsibility for the health of the public than has been our lot for many a year.

"I would like to review the purpose of this Society as given in the Constitution in Article II—"The purpose of this Society shall be to bring into one organization the physicians of St. Joseph County, so that by frequent meeting and full and frank intercourse of views they may secure such intelligent unity and harmony in every phase of their labors as will elevate and make effective the opinions of the profession in all scientific, legislative, public health, material and social affairs, to the end that the profession may receive that respect and support within its ranks and from the community to which its honorable history and great achievements entitle it."

Section 7 of Chapter II of the By-Laws states "This Society shall endeavor to educate its members to the belief that the physician should be a leader in his community, in character, in learning, in dignified and manly bearing, and in courteous and open treatment of his brother physician, to the end that the profession may occupy that place in its own and the public's estimation to which it is entitled.

As never before the Medical Society needs to act as a harmonious unit to attain the best results for both the public and ourselves.

We have all heard about the high costs of medical care but very few physicians have participated in the benefits or added to the costs.

After a five-year survey the committee on the costs of medical care has done a great piece of work but has accomplished practically nothing that we did not know. It is much like the five-year Russian plan. The majority report favored group practice—the minority favored the continuance of individual and private practice. This great question of socialized medicine greets us from all sides. It behooves every society to give this question deep and serious thought. Our Legislative Committee has a great responsibility. Socialized medicine seems to be on its way in one form or another and depends upon the united action and bold leadership of the medical profession to direct it into proper channels. We must act with a benevolent attitude and a careful reasoning spirit traditional of medicine. Personally I believe the American people are too individualistic ever to consent to state medicine. However, with a well organized group endeavoring to force state medicine upon us, we as physicians and surgeons should be well organized to express our ideas and ideals.

We must work with the public and for the public in the manner which will reflect the highest credit and honor to our organization. Without the respect and confidence and support of the public as a whole our cause as a society will be lost and we lose our force for good in the community. In distressing times like these the psychology of the people is a little unbalanced and injustices from both sides are bound to creep in. We must hold ourselves with open minds and be able to see other view points.

There have been a number of committees appointed and am sorry I did not have a place for everyone, but I now appoint each and every one of you as a committee of the whole with me for the benefit of yourself and for the uplift of the St. Joseph County Medical Society.

It was moved that a note of sympathy be written to Doctor Dugdale from the Society regretting his illness and his enforced absence as secretary, the first which had happened in his many years of secretaryship.

MARTHA BREWER LYON, M. D.,
Assistant Secretary and Treasurer.

January 10, 1933.

The regular meeting of the St. Joseph County Medical Society was held in the Oliver Hotel Tuesday, January 10, 1933, at 8:30 p. m., with President Graham in the chair.

The question of a permanent meeting place for the Society was discussed and the matter was turned over to the program committee for investigation and report.

President Graham read the names of his committees as follows:

Program—Drs. J. V. Cassady, J. E. McMeel, M. D. Wygant.

Library—A. S. Giordano, J. C. Boone, W. G. Wegner.

Necrology—M. F. Mitchell, J. B. Berteling, F. P. Eastman.

Annual Meeting—G. F. Green, C. C. Hyde, Edgar Myers.

Family Night—K. T. Knode, R. W. Spenner, V. E. Harmon.

Custodian—L. F. Fisher.

Public Health and Legislature—E. J. Lent, R. L. Sensenich, A. M. Sullivan.

The subject for the evening was "Influenza."

The following doctors participated in the program: J. B. Berteling, R. M. McDonald, E. T. Knode, A. S. Giordano.

The papers were discussed by Doctors Frith, Berteling, Allen, Vitou, Lyon, Eastman and Hill.

Doctor Cassady, Chairman of the Program Committee, announced that the next meeting would be a dinner meeting January 25, with Doctor Clarence Neymann as speaker.

MARTHA BREWER LYON, M. D.,
Assistant Secretary and Treasurer.

TRUTH ABOUT MEDICINES

NEW AND NONOFFICIAL REMEDIES

The following products have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association for inclusion in New and Nonofficial Remedies:

NOSTAL.—Isopropyl bromallyl barbituric acid. It differs from barbital (diethyl barbituric acid) in that both of the ethyl groups of the former have been replaced, one by an isopropyl group and the other by a substituted brominated allyl group. The actions and uses of nostal are essentially similar to those of barbital, but it is more active than barbital and is used in correspondingly smaller doses. It is marketed in the form of tablets 0.1 Gm. (1½ grains). Riedel-de Haen, Inc., New York.

ABBOTT'S A-B-D MALT EXTRACT WITH COD LIVER OIL AND VIOSTEROL 5 D.—Malt extract, 57 per cent; cod liver oil with sufficient viosterol to adjust the antirachitic potency to 5 D, 30 per cent by volume; glycerin, 10 per cent; alcohol, 3 per cent. The finished mixture is assayed for vitamin B_1 (F) potency by a modification of the method of Sherman and Spohn and is required to contain not less than 60 units per fluidounce; it is assayed for vitamin B_2 (G) by the method of Sherman modified by the diet proposed by Munsell and is required to contain not less than 60 units per fluidounce. The cod liver oil is assayed by the method of the U. S. P. X for vitamin A and is required to contain not less than 500 units per gram; it is adjusted by addition of viosterol to contain not less than 66.65 vitamin D units (Steenbock) per gram when assayed by the method of the Wisconsin Alumni Research Foundation. The actions and uses are the same as those for cod liver oil. Abbott Laboratories, North Chicago, Ill.—(*Jour. A. M. A.*, December 3, 1932, p. 1945).

NEOCINCHOPHEN-LEDERLE.—A brand of neocinchophen-N. N. R. It is marketed in the form of tablets 5 grains. Lederle Laboratories, Inc., Pearl River, N. Y.—(*Jour. A. M. A.*, December 31, 1932, p. 2265).

FOODS

The following products have been accepted by the Committee on Foods of the American Medical Association for inclusion in Accepted Foods:

GOLDEN OAK BRAND AMBER SYRUP (Wheeler-Barnes Company, Minneapolis).—A corn syrup base (85 per cent) with refiners' syrup (15 per cent).

LARABEE'S BEST FLOUR (Bleached) (Larabee Milling Company, Kansas City, Mo., subsidiary of the Commander-Larabee Corporation, Minneapolis).—A patent hard winter wheat flour; bleached.

DR. P. PHILLIPS' PURE FLORIDA ORANGE JUICE (Dr. P. Phillips Company, Doctor Phillips, Fla.).—Canned Florida orange juice sweetened with

added sucrose and retaining in large measure the original vitamin content.

MALTINE (Plain) (The Maltine Company, New York).—A concentrated extract of malted barley, wheat and oats containing vitamins B and G, diastase, and 3.9 per cent added alcohol. It is claimed to be an easily digestible carbohydrate food for supplementing the diet in vitamins B and G; contains diastase for aiding the digestion of starch.

DIXIE DREAM CAKE FLOUR (Bleached) (Larabee Flour Mills Company, Minneapolis, subsidiary of the Commander-Larabee Corporation, Minneapolis).—A soft winter wheat "long patent" flour; bleached. It is claimed to be especially designed for commercial baking of cakes and pastries.

FEDERAL BRAND EVAPORATED MILK, DARIGOLD BRAND UNSWEETENED EVAPORATED MILK (Consolidated Dairy Products Company, Seattle, Wash.).—Canned unsweetened sterilized evaporated milk.

STAUDT'S PULLMAN BREAD (Staudt's Bakery, Raleigh, N. C.).—A white bread made by the sponge dough method.—(*Jour. A. M. A.*, December 3, 1932, p. 1948).

LARABEE'S DIXIE DREAM CRACKER FLOUR (Bleached) (Larabee Flour Mills Company, Minneapolis).—A soft winter wheat "straight" flour; bleached. It is claimed to be especially designed for cracker baking.

GOLDEN GRAIN 100 PER CENT WHOLE WHEAT BREAD (Helms Bakeries, Ltd., Los Angeles).—A whole wheat bread made by the straight dough method.

MELLIN'S FOOD BISCUITS (Mellin's Food Company of North America, Boston).—Baked biscuits prepared from wheat flour, Mellin's food (essentially maltose, dextrins, cereal protein and minerals and potassium bicarbonate), cane sugar, oleomargarine and sodium bicarbonate. Biscuits intended for children passing from an infant's diet to more substantial nutriment and for invalids.

EMPRESS FLOUR (Bleached) (Larabee Flour Mills Company of the Commander-Larabee Corporation, Minneapolis).—A hard winter wheat "strong" patent flour; bleached. It is claimed to be designed for commercial bread baking.

BM MCO CREAM CORN MEAL (The Scott County Milling Company, Sikeston, Mo.).—Fine granular corn meal practically free of corn germ and bran.—(*Jour. A. M. A.*, December 10, 1932, p. 2033).

MERCK'S BANANA POWDER (Northjohn Corporation, Lincoln, N. J., manufacturer; Merck & Co., Inc., Rahway, N. J., distributor).—Spray-dried ripe bananas retaining enzymes and vitamins in accordance with the following approximations: vitamins A (100 per cent), B (100 per cent), C (20 per cent) and G (100 per cent). It is intended for table uses of bananas, the preparation of banana milk drinks, as a carbohydrate supplement for infant and invalid feeding and as an adjunct in special diets.

DR. P. PHILLIPS' FLORIDA FANCI-CUT ORANGE SLICES (Dr. P. Phillips Company, Doctor Phillips, Fla.).—Canned sliced Florida oranges sweetened with added sugar and retaining in large measure the original natural vitamin content.

SQUIBB CHOCOLATE FLAVORED VITAVOSE (E. R. Squibb & Sons, New York).—A powdered mixture of sucrose, vitavose (extract of malted wheat germ and U. S. P. malt), cocoa, skim milk and lactose; vanilla flavored; contains vitamins B and G. It is claimed to be intended especially for the carbohydrate, food iron and vitamins B and G supplement of milk.—(*Jour. A. M. A.*, December 17, 1932, p. 2113).

MELLIN'S FOOD (Mellin's Food Company of North America, Boston).—A dried extract produced by an infusion of wheat flour, wheat bran and malted barley admixed with potassium bicarbonate; essentially maltose, dextrins, proteins and mineral salts for the modification of milk for infants and invalids.

ELITE BRAND UNSWEETENED STERILIZED EVAPORATED MILK, KIT BRAND EVAPORATED MILK STERILIZED UNSWEETENED (The Page Milk Company, Merrill, Wis.).—An unsweetened evaporated milk. A mixture of one part water and one part of this product corresponds to the legal standard for whole milk.

BREAKSTONE'S CREAM CREST CREAM CHEESE, DAISY BRAND PASTEURIZED CREAM CHEESE (Breakstone Brothers, Inc., New York).—"Cream cheese" prepared from pasteurized cultured sweet cream seasoned with salt.

JELL-WELL GELATINE DESSERTS (Strawberry, Raspberry, Cherry, Loganberry, Mint, Lime, Lemon and Orange Flavors) (Jell-Well Dessert Company, Los Angeles).—These desserts contain sugar, gelatin, tartaric acid, U. S. Department of Agriculture certified color, and the following respective natural flavors: strawberry, raspberry, cherry, loganberry, mint, lime, lemon oil, orange oil.

PRUDENCE LAMB STEW (Boston Food Products Company, Boston).—Canned lamb stew containing lamb meat, potatoes, carrots, peas and onions; seasoned with salt and pepper.

M. D. CO. POWDERED MALT EXTRACT FOR MILK (Malt-Diastase Company, Brooklyn).—Spray-dried powdered malt extract, diastatically active; contains vitamins B and G. It is claimed to be especially intended for admixture with milk for use in the diet of invalids, convalescents, children, nursing mothers and the aged.

COLONIAL FLOUR (Bleached) (Blish Milling Company, Seymour, Ind.).—An "all purpose" "short patent" flour milled from soft wheat; bleached.

GORMAN'S RYE BREAD, SWEDISH RY-PAN BREAD (Gorman's Bakery, Inc., Central Falls, R. I.).—Rye breads made by the straight dough method.

IXL FAMILY FLOUR (Bleached) (Saxony Mills, St. Louis).—Hard winter wheat "long patent" flour; bleached.

FAIRWAY BRAND WHITE TABLE SYRUP (Wheeler-Barnes Company, Minneapolis, packer; Twin Ports Wholesale Grocer Company, Superior, Wis., distributor).—Corn syrup base (85 per cent) with rock candy syrup (15 per cent).

DR. P. PHILLIPS' FLORIDA FANCI-CUT GRAPEFRUIT AND ORANGES (Dr. P. Phillips Company, Doctor Phillips, Fla.).—Canned mixture of sliced Florida grapefruit and oranges sweetened with added sucrose and retaining in large measure the original natural vitamin content.

WILSON'S UNSWEETENED STERILIZED EVAPORATED MILK (The Indiana Condensed Milk Company, Indianapolis).—An unsweetened sterilized evaporated milk.

NONE SUCH BRAND TOMATO JUICE (Loudon Packing Company, Terre Haute, Ind., manufacturer; Durand-McNeil-Horner Company, Chicago, distributor).—Pasteurized tomato juice with a small amount of added salt; retains in high degree the vitamin content of the raw juice. It is claimed to be a good source of vitamins A and B and an excellent source of vitamin C.—(*Jour. A. M. A.*, December 31, 1932, p. 2266).

PROPAGANDA FOR REFORM

DANGERS OF THE INJECTION OF IODIZED OILS.—The Council on Pharmacy and Chemistry reports that it should be emphasized that the injection of iodized oils is essentially a surgical procedure, introducing a foreign and possibly irritant body and involving more or less risk, which should be weighed against the presumptive advantages, in comparison with the relative advantages and disadvantages of other measures. From the report of the Council it appears that the following cautions should be especially borne in mind: 1. Oils that have aged and darkened beyond their original color should never be used. 2. Subarachnoid injections should be avoided, at least until all other means of diagnosis have been exhausted. 3. Intratracheal and intrapleural injections should be avoided in tuberculosis of the respiratory organs and also when restriction of respiratory area would be contraindicated. 4. The injection pressure should be carefully controlled so as not to lacerate the tissues. 5. Intra-uterine injections should be made only under fluoroscopic observation. 6. Iodized oil should not be used for renal pyelography, except in the form of emulsion; and the injection should be stopped if pain is felt. 7. Intravascular injections with iodized oil appear too dangerous; the use of emulsions for this purpose requires further study.—(*Jour. A. M. A.*, December 3, 1932, p. 1946).

AMERTAN NOT ACCEPTABLE FOR N. N. R.—The Council on Pharmacy and Chemistry reports that Amertan is the proprietary name under which Eli Lilly and Company markets a preparation of Tannic Acid and Merthiolate in a water soluble jelly, proposed for the treatment of burns and the lessening of infection and complication. No evidence was submitted by the firm to show that this offers any clinical advantage over ordinary tannic acid treatment. The firm was informed that the product would be acceptable if marketed under an informing name such as "Tannic Acid Merthiolate Jelly." It refused to change the name of the product. The Council, therefore, declared "Amertan" unacceptable for New and Nonofficial Remedies because it is a mixture of insufficient originality to entitle it to a proprietary name and because no evidence is presented for its clinical advantage over other forms of medication in the conditions for which it is proposed.—(*Jour. A. M. A.*, December 3, 1932, p. 1947).

"NEW TOASTED CREAM OF BARLEY" NOT ACCEPTABLE.—The Committee on Foods reports that the American Barley Corporation of Minneapolis submitted a cereal called "New Toasted Cream of Barley," a lightly toasted, granular cereal consisting essentially of the endosperm and a portion of the bran of barley. The statements are in part grossly exaggerated, of a medicinal character, inappropriate for food advertising and misleading. Cream of Barley is fattening just as are any carbohydrate foods if ingested in quantities exceeding the body's demands. This cereal is not a "tonic for nerves and appetite." Such a statement is an attempt to attribute medicinal properties to the food. Claims that it contains "just the right proportions of carbohydrates, protein, mineral salts," are unsupportable. The copy for the label gives the impression of an effort to depict the product as containing "magic" medicinal virtues and thus to mislead and deceive. The manufacturer was advised of the opinion and recommendations of the committee, but these were ignored. Therefore, this cereal cannot be listed among the committee's "accepted" foods.—(*Jour. A. M. A.*, December 3, 1932, p. 1949).

DEANE R. BRENGLE, M. D.—Physicians from Maine to Florida are writing to THE JOURNAL sending a four-page advertising prospectus that they have received from Dr. Deane R. Brengle of Dearborn, Mich., in which Dr. Brengle states that he has for sale at the low price of one dollar "Forty Successful Treatments," comprising "a collection unique and valuable." Those who send the dollar receive a little pamphlet containing twenty pages, seventeen of which are devoted to the "Forty Successful Treatments." The prospectus indicates that Dr. Brengle's treatment for bronchial asthma was "discovered by chance"; the one dollar booklet states that it consists in injecting intramuscularly diphtheria antitoxin at intervals and administering, to control the paroxysms, a capsule that "is now available through my chemists, the A. E. Mallard Co. of Detroit." Dr. Brengle's treatment for boils consists in the administration of "Furnol," which apparently is a proprietary remedy also put out by the Mallard Company; his treatment for chorea consists in giving from 8 to 10 injections, intragluteally, of sul-

pharsphenamine; the treatment for chancroid consists in the intravenous injection of an aqueous solution of antimony and potassium tartrate, with iodoform as a local dressing; the treatment for herpes zoster (shingles) consists in withdrawing a small amount of blood from the patient's arm and immediately re-injecting it deeply into the gluteal muscles; his "specific remedy" for measles is amidopyrine; the "treatment of great value" for cancer is a proprietary preparation, allegedly of colloidal gold, exploited by the Kahlenberg Laboratories. Dr. Brengle also advertises that he has a "safe and successful procedure" to induce labor at term. For psoriasis the doctor has "a phenomenal remedy," consisting of the intravenous injection of typhoid-paratyphoid vaccine, followed by the intravenous injection of sodium cacodylate if the vaccine doesn't do the work; his treatment for chronic constipation merely consists in the "regular use of anti-constipation granules (Abbott)"; for diabetes mellitus he recommends the use of trypsogen in connection with the "diet list enclosed" with the preparation; and his treatment for eczema consists of sponging the eczematous areas with a mixture of corrosive sublimate and lime water, later applying ammoniated mercury ointment and giving internally thyroid extract and injecting intragluteally a non-specific protein. Dr. Brengle's collection is neither unique nor valuable. That he should expect physicians to contribute one dollar for his recommendations of unaccepted proprietaries is merely evidence of an extraordinary commercial sense.—(*Jour. A. M. A.*, December 3, 1932, p. 1969).

"Tonikum"-Roche (Elixir Arsylen Compositum) Not Acceptable for N. N. R.—The Council on Pharmacy and Chemistry reports that the phrase "Medicine of Rare Quality" appears on the trade package of Tonikum-Roche (Hoffmann-La Roche, Inc., New York). On the trade package tonikum is stated to contain in each fluidounce "Ext. Kolae glycerinat. saccharat. 'Roche' equiv. Sem. Kolae gr. 90; Arsylen 'Roche' (Natrium allylarsonicum) gr. ¼; Ext. Nucis Vomicae gr. 1/7; Natrium biphosphoricum gr. 18; Manganese gr. 1/10; Elix. Aromat. 'Roche' q. s. Alcohol 3½%." The preparation is offered as a "well-balanced tonic remedy for the stimulation of metabolic activities containing reconstructive agents of demonstrated value. . . ." The advertising for tonikum runs true to the classic "shotgun" type. Claims are made for the value of each constituent and then clinched with the general statement that they are combined "in small but properly balanced dosage, for ideal effect," implying that every patient evidently needs just these remedies in just these doses; and skeptics are reproved with the slogan, "With 'Roche' on the label you may feel confident of a good tonic"; so why take the trouble to think further? Taken as a whole, "Tonikum"-Roche is a "shotgun" proprietary "tonic" marketed under a therapeutically suggestive name with misleading therapeutic claims and in such a manner as to lead to its indiscriminate and ill-advised use by the public, which, when taken continuously, would tend to an undesirable accumulation of arsenic in the system. The Council declared it unacceptable for New and Nonofficial Remedies. The report of the Council was authorized for publication at the same time that advertisements appeared in the pharmaceutic press, stating that "The name of the new 'Roche' tonic Tonikum has been changed to Elixir Arsylen Compositum."—(*Jour. A. M. A.*, December 17, 1932, p. 2112).

The Nutritive Value of Pentose Sugars.—Recently the United States Bureau of Standards in a co-operative investigation announced a simple method of preparing xylose, a pentose from cottonseed hull bran, an inexpensive raw material. The wide publicity given to this announcement of the cheap production of xylose on a semi-commercial scale has lead to statements concerning xylose that may be misleading. Thus, xylose has been characterized as a "slenderizing sugar from cottonseed" and as a "non-fattening sugar." Miller and Lewis of the University of Michigan have considered the rôle of xylose (and the pentoses) in nutrition. In confirmation of the work of earlier investigators, xylose (sometimes called wood sugar) was shown to be absorbed readily, but at a rate much less rapid than was dextrose, and no formation of glycogen could be demonstrated after the oral administration of xylose, whereas similar tests with dextrose indicated the usual carbohydrate storage. Other observations likewise indicate that the alleged nutritive value of pentoses remains to be demonstrated.—(*Jour. A. M. A.*, December 17, 1932, p. 2115).

The Action of Copper in Iron Metabolism.—The importance of copper as a supplement to iron for the regeneration of hemoglobin in anemic rats was demonstrated four years ago by Hart, Steenbock, Waddell and Elvehjem. These investigators showed definitely, as Elvehjem and Sherman have recently pointed out, that, in the presence of copper, soluble inorganic iron salts can be used directly for the formation of hemoglobin. Since that time a number of workers have studied factors affecting the production of hemoglobin in rats rendered anemic by whole milk diets. Most of this work has verified the original conclusions concerning the importance of copper; and today nearly all workers agree that copper is an active agent in hemoglobin synthesis. As Elvehjem and Sherman conclude, copper does not affect the assimilation of iron but does function in the conversion of inorganic iron into hemoglobin. In recording these studies it seems desirable to remember that the extent to which the experimental studies are applicable to the human being remains for the most part to be established. Copper is far more widespread in foods than may be commonly supposed. The need for copper is quantitatively far smaller than the requirement of iron. The newer knowl-

edge should not be accepted as a warrant for uncontrolled administration of copper compounds to man. The facts regarding the possible actual needs and function of this element in human physiology remain to be more definitely ascertained.—(*Jour. A. M. A.*, December 17, 1932, p. 2114).

GOMCO SYRINGE STERL-CASE NOT ACCEPTABLE.—The Council on Physical Therapy reports that the Gomco Syringe Sterl-Case, manufactured and submitted by the Gomco Surgical Manufacturing Company, Buffalo, N. Y., may be described as a hypodermic needle enclosed in a compact vest pocket carrying case resembling a fountain pen. By means of an alcoholic preparation the needle is said to be sterilized and ready to carry. In the advertising matter accompanying the hypodermic needle it is claimed that the needle itself is "rustless" and the syringe case offers a means of complete syringe sterilization. While the needle may be made of the so-called rustless steel, it nevertheless rusts and becomes unfit for use after being carried in the pocket case syringe for about a week. Renewals of the needles at such short intervals would be objectionable. Because the needle rusts very readily and therefore becomes unfit for use, the Council on Physical Therapy declined to include the Gomco Syringe Sterl-Case in its list of accepted devices.—(*Jour. A. M. A.*, December 24, 1932, p. 2183).

THOROTRAST.—The Council on Pharmacy and Chemistry reports that Thorotrast was presented by the Heyden Chemical Corporation for consideration by the Council as a colloidal thorium dioxide preparation suitable for use in retrograde pyelography and for roentgen visualization of the liver and spleen by intravenous administration. Thorotrast is claimed to be a stabilized thorium dioxide "solution," containing 25 per cent by volume of thorium dioxide, ThO_2 (from 19 to 20 per cent by weight), and about the same amount of protective colloid (from 16 to 19 per cent by weight) said to be of a carbohydrate nature and further defined as a dextrin preparation. It contains as a preservative 0.15 per cent of methyl p-hydroxybenzoate. The alpha radioactivity of the usual intravenous dose of Thorotrast was determined to be approximately the equivalent of from 1.5 to 3.0 micrograms of radium. In consideration of the fatal poisoning from radioactive points reported in the literature, the Council believes this to be a highly dangerous dose. In view of the very imperfect elimination of thorium dioxide, its fairly high alpha ray activity, the possibility of further increase in radioactivity by partial conversion to mesothorium and radiothorium, and the possibility of sensitization of tissues to roentgen rays, considering the short period during which patients have been kept under observation, the Council voted that Thorotrast be not accepted for intravenous administration; that acceptance of Thorotrast for use in retrograde pyelography and for outlining various body cavities be deferred until more satisfactory evidence becomes available as to its therapeutic usefulness in these fields; and that acceptance of the proprietary name "Thorotrast" be deferred until satisfactory evidence becomes available that this preparation involves a fundamental improvement over other thorium preparations for use in roentgenography.—(*Jour. A. M. A.*, December 24, 1932, p. 2183).

COLLOIDAL GOLD AND CANCER.—"Collodaurum," a proprietary medicine said to consist of colloidal gold, is marketed by the Kahlenberg Laboratories, Inc., of Two Rivers, Wis. It is said to have been developed by Prof. Louis Kahlenberg of the University of Wisconsin and Dr. Edward H. Ochsner, and has been sold under the claim that it is "far superior to x-ray and radium in the treatment of inoperable cases of cancer, and also as postoperative treatment." As late as November, 1932, physicians have received circular letters urging them to try "Collodaurum" in cancer. In 1925 THE JOURNAL published a report of the Council on Pharmacy and Chemistry that pointed out that the claims for this product were not supported by acceptable evidence and were therefore unwarranted. THE JOURNAL has repeatedly said that, after all, time is the true test of any cancer cure. If a product offered for use in cancer had any real merit its praises after eight years would have been so widely sung that its manufacturer would not have to promote it by either circulars or advertising. The continued sale of "Collodaurum" is a sad reflection both on the scientific judgment of those who use the product and on those who lend their names to the promotion, and again an indication that cancer offers a fertile field for the promoter of any remedy for cancer that may be concocted.—(*Jour. A. M. A.*, December 24, 1932, p. 2188).

THE MARO COMPANY.—For some time there has been operating from Los Angeles a quackish concern known as the Maro Company, which has sold on the mail-order plan an alleged aphrodisiac called "Glandmaro" and, as an accessory, a preparation called "Energy Ointment." It appears from the memorandum submitted by the solicitor for the Post Office Department to the Postmaster-General, recommending the issuance of a fraud order, that the Maro Company was one of a series of medical mail-order enterprises originated by one I. R. Warn. In April, 1931, Warn is said to have sold the business to Max L. Harris for $750. Harris was not a physician, chemist or pharmacist, and employed neither chemists, physicians nor pharmacists. Glandmaro and Energy Ointment were sold under the claim that they would restore lost sexual vigor in men, cure prostate gland, kidney and bladder troubles, and prevent "vital losses," and were "absolutely harmless." When the federal authorities analyzed these products they found that Glandmaro suppositories contained red pepper, nux vomica, beef

and corn starch. The Energy Ointment was an orange-colored, perfumed, waxy grease with which was mixed red pepper! The government showed by expert medical testimony that the preparations were quite worthless for the purposes for which they were sold. Evidence was also introduced to show that Harris also sold a "Vacuum Exhaust Adjustor," one of the mechanical masturbators that are so popular with quacks. On July 11, 1932, the Postmaster issued a fraud order against the Maro Company of Santa Ana and Los Angeles, Cal.—(*Jour. A. M. A.*, December 24, 1932, p. 2201).

PONCE DE LEON LABORATORIES.—One R. James Gale started a fraudulent mail-order business under the name Ponce de Leon Laboratories at Miami, Fla., in April, 1931, according to the report of the postal authorities, who have just debarred the scheme from the mails. In January, 1932, Gale sold a half interest in this business to Verne R. Campbell and his wife, E. Dudley Campbell, and the business from then on was managed by Mrs. Campbell. The scheme consisted in selling a salve known as "Ponce de Leon Cream" for the alleged sexual rejuvenation of men. The postal authorities in their investigation found that this marvelous sexual rejuvenator was "nothing more than a red pepper salve." The memorandum of Judge Horace J. Donnelly recommending the issuance of a fraud order stated that medical expert testimony showed that while application of a red pepper salve to the scrotum would produce local irritation and possibly have some psychic effect, it would not, of course, sexually rejuvenate men of fifty, sixty or eighty years of age. The solicitor also brought out the fact that the Post Office Inspector who investigated the case was sold some of the preparation on the implied claim that it would sexually rejuvenate a man seventy-two years old who has lost his sexual vigor due to venereal disease and sexual excesses! (The order was issued November 29, 1932, p. 2201.)

CAROID.—Caroid is a preparation of papain (obtained from papaya). Years ago the Council on Pharmacy and Chemistry had Caroid under consideration for a considerable time and in the end rejected the product on account of its variability. At the present time no digestive ferment preparation proposed for oral administration stands accepted for New and Nonofficial Remedies for the reason that the Council has become convinced that there is no adequate evidence for the usefulness of the internal administration of such digestive ferment preparations. According to the advertising Caroid and Bile Salts contain Caroid, sodium glycocholate and sodium taurocholate, cascara sagrada, nux vomica, phenolphthalein and capsicum. It is therefore essentially a laxative mixture of needlessly complex composition.—(*Jour. A. M. A.*, December 24, 1932, p. 2204).

ERGOFORTIS NOT ACCEPTABLE FOR N. N. R.—The Council on Pharmacy and Chemistry reports that "Ergofortis" is the proprietary name under which Burrough Bros. Manufacturing Co., Baltimore, markets a liquid preparation of ergot stated to contain "in each cc. a specific ergot alkaloidal activity corresponding to 0.625 mg. of Ergotamine." According to the information submitted by the firm the product does not possess sufficient originality to justify the use of a proprietary name. In the circular much is made of the claim that the product is "25% more potent than the usual fluid extract." The Council has frequently held that a mere increase in potency is by no means always desirable, and in this case it is certainly not a convincing argument for the use of a proprietary name. The statement that Ergofortis is "protected from deterioration by the newly-developed method" is subject to serious question. At a recent meeting attended by representative manufacturers and the federal authorities, together with prominent pharmacists, it was agreed that there is no known method that can be depended on to protect a fluid preparation of ergot from deterioration. The firm of Burrough Bros. Manufacturing Co. was informed of the objections which the Council had found to Ergofortis and to the advertising circular. In reply the firm made no effort to meet these objections but stated that ". . . so far as we are concerned, the Ergofortis matter is closed." The Council, therefore, declared Ergofortis unacceptable for New and Nonofficial Remedies because it is marketed under an unacceptable proprietary name with incorrect and misleading claims.—(*Jour. A. M. A.*, December 31, 1932, p. 2265).

SODIUM THIOCYANATE (RHODANATE) AND THE THEORY OF AGGLOMERATION.—Both chemical and medical periodicals of late have contained discussions concerning a theory of sleep and a method for the control of narcotic addiction, and even insanity. The theory and a treatment are advanced by Wilder D. Bancroft, professor of physical chemistry in Cornell University, at Ithaca, N. Y. Apparently Professor Bancroft conceives that these conditions are associated with some physical change in the cells of the brain in the nature of an agglomeration and that this physical change can be controlled by the administration of sodium thiocyanate or sodium rhodanate. Physicians, of course, realize that it is the tendency of such cases to be cured temporarily by any treatment and that the difficulty in the situation arises in making them stay cured. It is conceivable that various types of mental defect may have remissions and numerous relapses. Evidence is now available in the office of the American Medical Association that Professor Bancroft has sent not only to physicians but also to a layman a circular stating that Sodium Rhodanate Merck, made and sold by Merck and Company, New York, is the purest sodium thiocyanate on the market and is the only one that they recommend at present, and gives directions for the use of the preparation. Among the strange inroads now being made on the practice of medi-

cine by those without training or legal authority to practice, this document assumes a peculiar place.—(*Jour. A. M. A.*, December 31, 1932, p. 2270).

ABSTRACTS

CONSERVATIVE TREATMENT OF ECLAMPSIA

From a study of the results obtained in a series of ninety-one consecutive cases of eclampsia, with a maternal mortality rate of 5.4 per cent, C. B. Upshaw, Atlanta, Ga. (*Journal A. M. A.*, Dec. 17, 1932), believes the following conclusions are justified: 1. The best results are obtained by controlling the convulsions before any attempt is made to induce labor. 2. An initial dose of morphine sulphate, ¼ grain (0.0162 Gm.), should always be given; then 20 cc. of a 10 per cent magnesium sulphate solution intravenously, followed by intramuscular or intravenous injections at hourly intervals to control the convulsions. 3. Concentrated (25 per cent) dextrose solution intravenously in 300 cc. injections is given at eight hour intervals to assist in reducing cerebral edema and in maintaining blood volume, and also to stimulate diuresis. This must be continued for two days after labor, or, in severe types, after control of convulsions. 4. Labor is initiated by rupturing the membranes and allowing the anniotic fluid to escape. This method has been successful and has been the least disturbing to the patient. 5. A policy of nonintervention in labor is best for the mother. Opiates are given as needed to limit the pains. 6. Anesthesia should be limited as much as possible. Light ether anesthesia is perhaps the safest. No anesthetic should be administered to patients in a semicomatose or comatose state.

RESISTANCE TO POLIOMYELITIS: RELATIVE IMPORTANCE OF PHYSIOLOGIC AND IMMUNOLOGIC FACTORS

According to Claus W. Jungeblut and Earl T. Engle, New York (*Journal A. M. A.*, Dec. 17, 1932), the widely accepted hypothesis which postulates that the resistance of adults to poliomyelitis is due exclusively to universal subclinical immunization against the virus is inconsistent with a number of epidemiologic observations bearing on the age distribution in various latitudes and the recent trend toward an advance in the age line. The assumption of a unique immunizing power of the virus in the absence of disease production cannot be verified experimentally. The opinion that natural virucidal substances in the serums from human adults can develop only through previous contact with the specific antigen is open to criticism because of their apparent formation in man and monkeys under conditions which preclude the presence of the virus. The evidence in support of the current concept that the incidence of virucidal serums in human adults stands in direct relation to the density of population should be reviewed since individual serums may show wide discrepancies in virucidal power, which seems to vary with the blood group and to fluctuate with changes in the physiologic state of the body. In a restricted number of instances it has been possible to demonstrate that virus-neutralizing substances may occur in the serum of immature monkeys after prolonged treatment with anterior pituitary extracts or similar principles recovered from the urine of pregnant women. The authors offer the suggestion that the mass protection enjoyed by the adult human population rests primarily on the normal function of the endocrine balance characteristic of mature age.

OXYGEN THERAPY

In his article on oxygen therapy Walter M. Boothby, Rochester, Minn. (*Journal A. M. A.*, Dec. 10 and 17, 1932), reviews the literature and states that, in America, interest in oxygen therapy was stimulated by the construction at the Rockefeller Hospital by Stadie of an oxygen chamber which was later rebuilt by Binger. He emphasizes the fact that oxygen therapy, properly administered, has been found to be of marked benefit, and often even a life-saving measure, in nearly all cases of acute anoxemia. The best possible results from oxygen therapy are to be obtained by the use of oxygen chambers in which the patient has all the bodily comforts, without impairment of nursing efficiency. Excellent results can be obtained from the use of the recently improved models of oxygen tents, if they are properly run by experienced persons. The concentration of oxygen in the tent, at or near the sea level, should never exceed 60 per cent and should preferably be maintained as close to 50 per cent as possible. This is a concentration approximately two and a half times that of natural air. Analysis of the concentration of oxygen should be made three or four times daily, and the result recorded either on the temperature chart or on a separate oxygen therapy sheet. The carbon dioxide given off with each expiration must be removed from the air circulating in the closed circuit system. If this is not done, the concentration of carbon dioxide will rapidly increase above the desired upper limit which, for most patients, is about 1 or 1.5 per cent. If the concentration further increases above this figure, breathing will become progressively deeper and then will become unbearable and finally dangerous, around 4.5 to 5 per cent. The carbon dioxide is effectively and economically removed by the use of soda lime, which is placed in a separate compartment of the circulating air current on the same principle as that on which soda lime is used in the closed circuit type of the basal metabolism apparatus. The length of time during which soda lime will remain efficient will depend in part on the rapidity with which the patient forms carbon dioxide. The author further describes the methods that can be used to make the air circulate through the soda lime box for the absorption of carbon dioxide. The author states that in the absence of an oxygen tent a temporary emergency type of apparatus should be made, for which he gives directions.

SOME STUDIES ON MIDDLE EAR INFECTION

James A. Babbitt, Philadelphia (*Journal A. M. A.*, Dec. 31, 1932), presents some further studies and opinions on the practical treatment of persistent middle ear infection. For purposes of his study a separate classification of the true otorrheas and ears presenting persistently recurrent discharge was not made. From a practical standpoint, such a discharge, even with slight intermissions, and without obvious background for the recurrence, presents a routine problem. Acute and chronic suppurative otitis media presupposes extension of infection from the nasopharynx through the eustachian tube, by direct transmission from the blood or lymphatic stream (thrombotic in the exanthems) or by extension from infection in the external auditory canal. Infections in the nasopharynx or posterior ethmoidal area of the nares, septic tonsils, teeth and sinuses are of importance, and the management of presenting intratympanic involvement demands a careful scrutiny of these areas. As a sequence of persistent infection bears such close relation to the adequate diagnosis of the tympanic membrane, its drainage in the proper manner and at the proper time, the value of the picture presented by the line of the malleus, and its short process, the vascularity bordering the annulus and along the malleolar line, the differentiation of surface myringitis and the occasional horizontal fluid line should all be emphasized. A careful comparison with the unaffected ear with perfect illumination will aid in the opinion as to Shrapnell's area. The incision should be a long one, if the tympanic membrance is to be opened, commencing near the posterior commissural fold, well away from the vessel supply of the anulus and well around at the base. One incision ought to suffice save to remove congealed secretion, for later incision encounters inflammatory sequence and scleroses, and secondary drainage is often more damaging than satisfactory. There is no evidence that hasty operation on the mastoid leaves the ear in a better condition than one spontaneously quieted through careful drainage and rhinopharyngeal attention. Perhaps sufficient study of ossicular mobility in later years in relation to hearing and tinnitus might disprove this. The single point to be made is, if the ear is to be opened, one should do it thoroughly and once for all.

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ORIGINAL ARTICLES

OBSTETRIC MORTALITY*

A. M. MENDENHALL, M. D.

INDIANAPOLIS

We are quite familiar with the frequently quoted mortality rates for the United States; perhaps they have been presented too often. I shall, therefore, only briefly mention a few of the high points in the maternal mortality figures as assembled by the White House Conference on Child Health and Protection, since these are the most authoritative and dependable statistics ever attempted in this country.

MORTALITY RATES

The total maternal death rate for the United States is 6.5 per 1,000 live births, and this places us as twenty-second among civilized nations. It is interesting to note that Uruguay heads the list with 2.2 rate. The rate for the State of Indiana in 1931 was 5.6.

In round numbers, there are 20,000 women dying annually in the United States as a result of the child-bearing process. Of this astounding number, approximately one-third of the deaths are due to sepsis and one-fourth to toxemia. This makes 58% of the deaths due to two major diseases and to diseases which should be almost entirely prevented. It permits no argument to say that nearly all sepsis is preventable.

If only the precepts laid down by Oliver Wendell Holmes in 1843 were religiously followed, these 7,000 deaths from sepsis would be almost eliminated. We admit the possibility of a few cases of auto-infection, and a very few other cases of infection which with present day knowledge cannot be prevented, but the number is very small indeed.

Within the month a patient has been admitted to my obstetric service who was a primipara and had been delivered in a private home under very unfavorable circumstances. After much too short a time had been given for normal labor to progress, she was given an ether anesthetic, a wide episiotomy was done, and this was followed with a forceps delivery. A repair was attempted by the insertion of two large sutures through all the perineal layers. All this was done through an entirely un-shaved, un-clipped vulva. Three days later she was sent to the hospital in a violent puerperal sepsis.

Why the forceps delivery at all? If necessary to deliver by forceps, why not in the hospital? If necessary to deliver by forceps and in the home, why not at least give her a little better fighting chance by shaving and preparing her vulva, and by following a few of the accepted criteria for modern asepsis and antisepsis?

As to toxemia, there is less positive proof of our ability to prevent it, but one competent obstetrician says that when we have a toxemia death, some one has erred. Either the patient delayed too long in obtaining medical care, or medical care when obtained was inadequate and not in accordance with established knowledge of the subject. Whether or not the statement that all toxemia can be prevented is a trifle too strong, the fact remains that if women could all be educated to engage a physician early in pregnancy, and if the physician is trained to give proper prenatal care and to recognize promptly the danger signals in toxemia, the death rate in this disease should approach the zero point.

ECLAMPSIA

In five years' record of the Indiana University Hospital only one case of eclampsia has been sent to us from our own prenatal clinic, and in this particular case, we were able to find that a mistake had been made in failing to admit her to the hospital when her elevated blood pressure and albuminuria should have been more religiously heeded as danger signals. This represents 4,400 deliveries. During this same period of five years, we have had 59 cases of eclampsia. These figures are not offered as being peculiar to our own institution but are quite in harmony with the better maternities throughout the world.

Much progress has been made in recent years in recognizing danger signals upon the approach of toxemia, and if recognized during the pre-convulsive stage, our treatment is of much greater benefit. In other words a large percentage of

* Presented at the Michigan City session of the Indiana State Medical Association, September, 1932.

patients can be saved if the toxemic condition is recognized and properly treated during the pre-eclamptic stage. Headache in the third trimester must never be looked upon lightly. Likewise insomnia must be investigated carefully as it is quite frequently a pre-eclamptic symptom. One needs only to mention that a high blood pressure or a slowly rising pressure should be considered as prodromal of eclampsia. Albuminuria, edema, disturbances of vision and vomiting late in pregnancy should serve as warnings of impending toxemia.

The treatment after the convulsive stage has been reached cannot be dealt with here further than to repeat that success in prevention is much more certain of accomplishment than is any curative measure so far known, and to say that an immediate routine cesarean section in eclampsia is followed with a definitely higher maternal death rate than would be obtained by a more conservative plan of treatment. Proper prenatal care and skilled obstetric care in recognition of the many warnings of impending eclampsia should almost eradicate this death-dealing disease from our maternal mortality records.

Therapeutic Abortion

Early recognition of the approach of hyperemesis gravidarum and the institution of well established procedures should almost, if not entirely, eliminate the necessity of emptying the uterus for this disease. Not one therapeutic abortion for pernicious vomiting has been done on my service at the University Hospital or the Indianapolis City Hospital or in private practice in ten years, and not one life has been lost from this disease. Treat these cases early and correctly, and it will be rare indeed that abortion will become necessary or that the mother will be sacrificed. Once a therapeutic abortion has been performed on a patient for pernicious vomiting she becomes a very difficut patient to handle and to dissuade from abortion in any subsequent pregnancy.

General and Maternity Hospitals

One more set of figures assembled by the White House Conference is quite interesting and instructive. I refer to the fact that maternal death rates were found to be much higher in general hospitals than in maternity hospitals. The reasons, I believe, are obvious. What may we do to bring about better conditions?

First of all I desire to sound a word of warning against meddlesome obstetrics and radicalism. More conservative obstetrics will quickly lower mortality rates. Large numbers of cases are deliberately rendered pathological by interference with natural processes and with the normal mechanism of labor. Far too many cesareans are being done. Cesarean section is spectacular, is quickly done, and conserves the accoucheur's time and sleep, but needless cesareans are adding continuously to maternal deaths. The opening of a new county hospital does not mean that the time has arrived for babies to be born through abdominal incisions. One such hospital was opened in Indiana, the first two major operations were cesareans, and both mothers were lost. He who is unaware that vaginal deliveries are still safer than abdominal, has failed to note the voluminous literature on the subject.

The same is true of internal podalic version. Dr. Potter has taught us much about versions and has definitely widened our indication for this method of delivery, but he who believes that the average woman in labor can be more safely delivered by version is not well informed on the subject of this paper—obstetric mortality.

We could make much favorable comment upon DeLee's prophylactic forceps deliveries, and we are quite certain that this procedure has a definite place in modern, scientific, skilled obstetrics, but its routine use and its indiscriminate adoption by those not specially skilled in obstetric surgery can only add to our preventable mortality and morbidity lists. Fewer forceps deliveries, no forceps deliveries until the cervix is fully dilated, rarely if ever a high forceps delivery—these should be our mottoes if we are to improve our results.

Fewer vaginal examinations late in pregnancy, during labor and during the early puerperium will make for better results.

No pituitary solution in labor will reduce our maternal death rate immeasurably. This dangerous drug, now exploited to the medical public under many catchy names and misleading, if not absolutely false statements, unfortunately is being picked up by the obstetric attendant who is unwilling to give the proper amount of his time to a case of labor. It is a splendid aid to the accoucheur in conserving *his time*, but since our primary interest should be in the mother and baby, we have no hesitancy in saying that it is a hazardous, dangerous drug whenever used in labor. It is valuable in the treatment of post partum hemorrhage.

In summarizing the above warnings, I would say that short cuts for the accoucheur and easy, quick methods of delivery are adding to our unnecessarily high maternal mortality. The practice of good obstetrics requires an immense amount of patience; it requires physical and mental endurance; it requires self-sacrifice; it requires actual time; it requires psychotherapy; it requires tact; and it requires a strong defense mechanism toward short cuts.

In reducing maternal mortalities it is important that the lay public become better and better informed as to the importance of good care during pregnancy, labor and the puerperium. Up to date very little has been done toward spreading this information except by our state board of health which, with Dr. King at the head and Dr. Schweitzer working along these lines, has done an immense amount of good. So far as they are able

to proceed with the limited funds at their disposal and their limited personnel, it is very gratifying to find the many evidences up and down the state of their splendid efforts. The medical profession as a *whole* should always be messengers of information as to better medicine in general and better obstetrics in particular.

Obstetric Teaching

The White House Conference arrived at the conclusion that the quality of obstetric care is the most important single factor in determining the obstetric mortality rate. Why the quality of obstetric care may not always be good is, of course, due to many conditions. First among these is the quality and quantity of obstetric teaching. Even though it is generally recognized that approximately one-third of the practice of young physicians in their first three years following graduation will be obstetrics, many schools still give very inferior positions to obstetrics in the curriculum. Large numbers of cases are necessary for the proper teaching of obstetrics, because obstetrics is essentially a clinical and not a didactic subject, and because the teaching capacity of an obstetric case is very limited. Large maternity wards, large prenatal clinics, and under certain conditions large outdoor obstetric services are essential if the average class of 100 students can be at all well trained in obstetrics.

Time does not permit a discussion of the teaching of operative obstetrics further than to say that the way it is now being taught in many schools is fraught with much danger. Unless much more clinical material is made available and unless much more time is allotted to obstetrics than is done in most medical schools, it is probably better to teach little operative obstetrics to undergraduates, but demand that this knowledge be obtained by a compulsory year's internship where adequate obstetric services exist. Even this will fall far short of producing obstetricians. A two to three year post-graduate course and residency in obstetrics is fundamental before major obstetric surgery is undertaken. The most that average obstetric departments can hope to teach under present conditions is good care of the so-called normal obstetric case.

Many obstetric educators now advocate that each student, before graduation, should be required to attend, under good supervision, at least fifty cases of labor. This may sound Utopian, but the day is not very far distant when we will cease turning out neophytes in medicine supposedly ready to assume the responsibilities of an obstetric case with far from adequate training, and when that day is reached, maternal death rates will begin to decline.

For the physician already in practice, there are many helpful post graduate courses. The ordinary post-graduate course which does not include a residency in a good maternity hospital falls very far short of producing obstetricians, but does serve as an excellent opportunity in reviewing obstetrics and becoming more or less familiar with progress taking place in this field. It sends the physician back to his clientele with a broader view of the subject, a greater appreciation of the importance of obstetrics and with some added knowledge of how to better safeguard his patients.

I would urge upon all those doing any obstetrics to become familiar with recent developments of methods for pain relief during labor, notably rectal analgesia. The late Dr. Asa B. Davis in his presidential address before the American Obstetrical Association spoke of this procedure as an *epoch* in modern obstetrics. Rectal analgesia can be safely used by any physician in any environment, and should not be overlooked.

The intravenous use of glucose in both early and late toxemia of pregnancy is a very valuable addition to our therapeutic armamentarium, and is also a procedure which can be used quite safely under even the worst surroundings.

The last few years has seen the x-ray come in for more and more use as an aid in obstetrics. It is of some aid in diagnosing the size and shape of the maternal pelvis; it may often be used to advantage in diagnosing as to whether one is dealing with twins or a large single baby; it is also helpful in diagnosing macerated fetus, hydrocephalus, polyhydramnios, fetal deformities, etc.

Probably the greatest single step forward in obstetric surgery in recent years is that of the introduction and development of the newer types of cesarean sections, whereby the potentially infected woman may be far more safely operated than by the classical section. Classical cesarean section on potentially infected cases has been almost entirely abandoned by obstetric surgeons in general in their efforts to reduce mortality and morbidity.

Summary

1. More conservative obstetrics would markedly reduce maternal death rates.
2. Avoidance of short-cut methods which are of value only in conserving the attendant's time would be a step forward.
3. Better undergraduate education in obstetrics is important.
4. Post graduate work in obstetrics is of value to a limited extent.
5. More trained obstetricians are needed.
6. Wider education of the laity as to the importance of the child-bearing process is desirable.
7. More maternities are needed.
8. Some type of regulation or supervision of private and public hospitals caring for obstetric patients is recommended.
9. Most if not all therapeutic abortions for hyperemesis gravidarum should be avoided.
10. Attention to obstetric literature and familiarization with newer developments in the field of obstetrics should bring about better results.

DISCUSSION

ERNEST L. SCHAIBLE, M. D. (Gary): I am very much interested in this paper, particularly in that part of the paper that has to do with the training of obstetricians, and, of course, in the mortality rate. It seems to me that the United States has just as well-trained physicians as any country in the world. In fact, our educational requirements are just as high as in any country. Why is it that we have such a high mortality rate? I think one of the things that causes this is that we are more honest in our statistics. In going over the statistics of a hospital with which I happen to be connected, only a small hospital, I find the death rate is just about that mentioned by Dr. Mendenhall, for the State of Indiana, that is, 5.9 per cent. That is too high, possibly, but in going over the cases I find a great many of them had tried to be delivered in the home, and had been infected; two cases had septicemia before they came to the hospital.

In the teaching of obstetrics there is no question that our schools fall far short. They get a few cases, they observe a few cases, and what is the result? They have not had any actual work. We should have students going out, under supervision, to take care of obstetrical cases, so when they have their own cases they will know how to handle them.

In the case of cesarean section, I looked up the cesareans at our hospital and found that out of 1,340 cases in the last four years, there were 15 cesareans, with one death. That death possibly was not the fault of the physician as the case had ruptured membrances for three days; it was a bicornate uterus, transverse position, and there was no attempt at delivery; a cesarean was done and the patient died of septicemia.

I believe if the teachings of Dr. Mendenhall are heeded by all the doctors doing obstetrics, we certainly will lower the death rate.

POINTS OF CONTACT BETWEEN THE GENERAL PRACTITIONER AND THE OTOLARYNGOLOGIST*

WILLIAM S. TOMLIN, M. D.
INDIANAPOLIS

It is the purpose of this communication to outline and to present some views on the advantages, importance and necessity of contact between the oto-laryngologists and other practitioners. More particularly is it desired to encourage the spirit of mutuality in their common cause of humanity, the laying aside of prejudice and the avoidance of friction, real or apparent, between these fields of endeavor. Our ultimate aims are the same and require only mutual recognition and understanding best to serve all and especially the patient.

At no time in the past has our profession been able to do so much for health, nor has it given so much of its time and services, and yet it does not seem to be receiving the recognition that the efforts and the results deserve. Perhaps some of the reason is to be found in our own relations and it is to be hoped that we may grow more in the public esteem by cultivating a better relationship in our own ranks. Moreover beyond these considerations lie the basis of the specialist, which must be on the general field and the further growth of the general practitioner, added to by the developments in the narrower confines. Thus their contact may be mutually helpful and effective.

DIAGNOSIS

The importance of a complete diagnosis can hardly be overestimated and where there is overlapping from one part of this to the other the sum of findings from both is frequently essential in seemingly simple cases. The child complaining of an earache apparently as an entity or in the course of previous pathology has at stake an important sense and more serious involvment. The decision whether a paracentesis will be most useful is of sufficient importance to require some expert knowledge. The drum may be highly injected, the pain intense, and yet an incision unjustifiable and exactly the wrong thing to do as it may result in introducing infection into regions not yet involved. If an incision is to be made it does not suffice to stab the drum in some indifferent location, this to be repeated from day to day in the ineffectual attempt to arrive at thorough drainage. Some one, with the field in good vision, needs with an upward stroke, to make a semilunar flap incision so that an outward flow maintains patency and with its cessation the flap falls back into place restoring this protection to the inner parts. The development of surgical mastoiditis and other serious complications and sequelae in the hands of, or under the guidance of, a competent otologist is of a rarity much to be desired. Chronic discharges from the ear are a real menace to the functions and not infrequently to the general health, in addition to direct serious extension of pathology. Such would not be allowed to continue without effort in a domestic animal and why its menace is taken so lightly by some parents and individuals is difficult to understand.

Impaired hearing is another complaint taken so lightly that not infrequently irreparable damage has occurred before competent treatment is sought in cases that in the early stages were simple in diagnosis and easily remedied.

Further on the specialist may be equally in need of the internist, neurologist or other sources of advice to assist him in determining the best course to pursue. It is no disparagement to either that the other is better able to see, weigh and select from the data in his domain the most salient features and to give assistance in selecting the best lines of management.

* Presented at the Michigan City session of the Indiana State Medical Association, September, 1932.

In good history taking all of us must be impressed with the number of cases traceable in origin to the common cold and especially to such as persisted, and here is a point at issue. Granted that most of these cases beginning with acute nasopharyngitis may and do recover with rest and some simple internal medication, as do many other inflammatory conditions, yet here is one where the local point of attack is within reach and subject to investigation and remedy with direct rational treatment. Any of these cases that have not yielded promptly to systemic measures require, on the part of some one, eradication of the primary source. Likewise, when, as will happen in spite of best directed efforts, complications do occur, another skilled in caring for them may be contacted with advantage to the patient. To be mentioned in particular is hoarseness which, continuing in early life, may damage the speaking and singing voice permanently, and in later years chronicity is always suspicious of malignancy.

In the exanthems arise many points of contact, the first and not by any means the least, the prophylaxis against complications. Irrigations of the nose and naso-pharynx, especially in the hands of the untrained, may serve only to uncover protected regions and to force infection into sinuses or eustachian tubes. Aqueous solutions *forced* into these regions are sedulously to be avoided, especially when they are already known to be involved. Likewise the irrigation of discharging ears when the drum is perforated serves to waterlog the tissues, to carry in more infection than is taken out and to lead to the involvement of deeper structures.

Very fertile sources of useful contacts arise in the fields of socalled rheumatism and neuralgia. These are syndromes in which a search for cause leads in all directions and procedures for relief are equally complicated and varied. Original foci are of such frequency in the head and throat that no examination is complete without their inclusion and whether the foci here found are primary or secondary, cooperation to find and eliminate others is needful and often further conjoined efforts for lasting relief are indispensable. Arthritis deformans continues cryptogenetic in many instances and yet most of us have seen cases where the pain and tenderness have ceased in a few hours after a focus of infection has been removed.

Headaches of many types call for the contacts that we are considering. Patent nasal suppuration is not necessary to point the way to toxins or nerve pressure here, as the hyperplastic form of inflammation in these regions is not always so accompanied and it is an important factor in producing severe and persistent types of headaches. Likewise, with the most careful search and endeavor to relieve this distressing affliction which has seemed to arise in this field, the rhinologist many times should have assistance from other sources. In the recognition of complications and interdependence of gastro-intestinal disturbances and suppurative conditions of the ear, nose and throat the call for cooperation may come from either source. The upper tract chronic infection may resist relief until general resistance supplies recuperative energy, and abundant mucopurulent discharges may be unremitting until engorgements of portal or other abdominal circulation are corrected. Likewise an inefficient digestion may in part be hinged upon a trickling from above of a mechanical mucus or fermenting agencies impossible to sterilize except when attacked at their origin. Some cases of the present popular colitis are being found demanding for their relief a surcease of infections in the head and throat. Appendicitis and cholecystitis, acute, and chronic, especially in exacerbation, long have been associated with recent tonsil and sinus infection.

The cause and effect relations between mastoiditis and enteritis in early childhood are yet subject to differences of opinion. Emphasis naturally follows the individual experience and for the present a divided responsibility yields increased satisfaction to the attendants and additional hopes for the patient. Politzer long ago gave us the information that the mastoid is involved to some degree in all cases of acute otitis media. Bearing this in mind one should be alert and never be surprised when its active manifestations change the picture to one of more serious import. Admitting without question that a majority of these cases recover with the simplest care it does not follow that indifference has a place either before or after a suppurative mastoiditis is shown with periostitis, maybe with a Bezold abscess, as is to be expected especially in childhood. Such complications are of especial importance when accompanying or following one of the exanthems so prone to leave permanent deafness because the toxins attack the eighth nerve. Constitutional conditions during and following all sinus suppuration, including the mastoid antrum, render combined skill and effort essential for best results. Contacts with the ophthalmologist are so frequent and so well known that a mere mention may suffice.

Infection of the bronchi find their way through the sinus-surrounded nose and throat, and send back additional causes of virulence. Bronchoscopic resources in foreign bodies, abscesses and atelectasis both in diagnosis and treatment call for reliable cooperation on both sides. We could not do without the roentgenologist, and the laboratory long ago became indispensable; but neither nor both can take the place of a good history and a genuine clinical examination.

Recognition of allergy is of increasing importance and the rhinologist, not caring to enter this field extensively, profits in collaboration. Valueless operations may be avoided through recognition of allergic conditions in the air passages as well as

failures to obtain complete relief from proper desensitization when imperfect passages have constituted a material part of the difficulty. So it is that neither attendant alone would do full justice and either might be subject to criticism more or less deserved.

No attempt is made to list all the points of contact as that would be consuming too much time on lesser matters.

What would please us most is to contribute something to the medical fraternity and through that to promote the better understanding and appreciation of the general public. It is helpful, but not sufficient, that as individuals we have something of these from each other. Cults and schisms in the healing art have been in all our history and their negative advantages in less enlightened times, seem more easily understood than now. Their favorite point of attack has been and is found in our own lack of mutuality. So many sources of controversy have been cleared up in recent decades through advances in scientific certainty that while undoubtedly we are making progress it seems slow in comparison with its possibilities. Particularly this seems to be true as regards the public. One never lowers estimation of himself in recognizing ability in others and speaking in kindly praise of his confreres. That aids the individual and the whole profession.

Surely no stigma attaches to one when he recommends another as skilled with the stethoscope or microscope or interpreting with other measures, any more than that another by virtue of study and practice can see more with a head mirror, or can use a bronchoscope with better safety than himself. The patient is and always must be the chief object of concern. His return to health with the least suffering, in the shortest possible time, and with the least hardship constitutes our ideal in the healing art.

CUTANEOUS MANIFESTATIONS OF GENERAL DISEASES*

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It has often been said, and rightly so, that the skin is "the mirror of the body." Aside from its fundamental importance as an organ of protection, excretion, secretion, and heat regulation, studies during the past twenty years tend to show its intimate relation with morbid processes lying deeper within. As the years have passed, many of the so-called essential dermatoses have been proved to be the cutaneous reflection of some general pathologic state. This correlation of skin manifestations with disease involving the organism as a whole is exemplified by Barney,[1] who reviewed the cases of so-called pityriasis rubra which had been reported. Pityriasis rubra means only red scaling, and was first described by Hebra when dermatology was in its infancy and on purely a morphologic basis. Barney[1] found that in practically all of the cases there was a marked systemic involvement, many of the patients presenting blood dyscrasias which warrant their inclusion in the lymphoblastoma group. Pityriasis rubra or exfoliative dermatitis as it is now looked upon, is accepted to be only a sign, the etiologic factor of which may be various causes, both external and internal. Many other workers have made noteworthy contributions which have tended to narrow the gap existing between dermatology and medicine in general. The progress of scientific medicine in the last quarter of a century, particularly metabolism and biochemistry, has played a big part in extending the narrow limits of dermatology, and aided in the correlation of this specialty with general medicine and the other medical specialties. It is the purpose of this paper to call to your attention some cutaneous conditions that are associated with pathologic processes deeper within, the latter in many instances being of graver significance and importance to the patient than the former.

TUBERCULOSIS

Tuberculosis presents a variety of clinical pictures when involving the skin. It may be primary, but most often an underlying pulmonary, osseous or glandular focus can be found. Today we recognize two groups of cutaneous manifestations due to or associated with tuberculosis. In the first group are placed those conditions presenting a tuberculous architecture microscopically, and include lupus vulgaris, tuberculosis cutis orificialis, tuberculosis verrucosa cutis, and scrofuloderma. In the second group are placed erythema induratum, lichen scrofulosorum, the papulonecrotic tuberculides, and the sarcoids. In the former group the skin affection is always secondary to tuberculosis of some internal organ, except in tuberculosis verrucosa cutis which may develop following contact with tuberculous material. The diagnostic value and clinical significance of this group needs no further comment.

The second group has been variously designated tuberculides, toxituberculides, and paratuberculides. In 1896, Darier[2] first placed these conditions in a group and designated them as tuberculides. They do not conform to the picture of cutaneous tuberculosis as seen in the first group, and are characterized by their benign course, tendency to recurrence in successive crops with spontaneous involution, and a histologic picture simulating tuberculosis.

Erythema induratum, a chronic inflammatory disorder, is seen most often in girls or young women. The lesions are confined to the calves of the legs, begin as subcutaneous tender nodules, which later

* Presented at the Michigan City session of the Indiana State Medical Association, September, 1932.

[1] Barney, R. E.: Arch. Derm. & Syph., 18:716, 1928

[2] Sutton, R. L.: Diseases of the Skin, Eighth Edition, 1931, Page 849.

involve the overlying skin, giving it a bluish-red color. The nodules may undergo absorption or break down and ulcerate.

Lichen scrofulosorum occurs in tuberculous children, and presents as groups of flesh-colored to pinkish papules. These have a follicular distribution, and in the course of time become brownish and covered with a fine scale. The site of predilection for this eruption is the sides of the trunk.

The papulonecrotic tuberculides, acnitis and folliclis, occur on the face and extremities. They present as follicular, reddish papulo-pustules. Ultimately they dry down and the crusts drop off, leaving an atrophic scar surrounded by pigmentation.

The tuberculous relationship of the sarcoids is still a matter of debate. Four types have been described, but only the multiple benign type of Boeck, and subcutaneous variety of Darier-Roussy will be considered here. The former presents as yellowish, reddish, or brownish nodules and plaques involving the face and the extremities. They respond to arsenical medication, leaving at times a thin, atrophic scar after involution. The latter involves most often the trunk, appearing as subcutaneous nodules as large as a walnut. The overlying skin may remain normal in appearance, or may take on a dull purplish color. Except for their location, painlessness, and the fact that the lesions seldom ulcerate, they resemble clinically the lesions of erythema induratum. It is thought by some that the two diseases are identical.

From the foregoing it is quite apparent that tuberculosis may manifest itself in the skin in a wide variety of ways. The proper recognition of these lesions and their value as diagnostic aids in uncovering tuberculosis deeper within is unquestionable.

Focal Infection

The theory of focal infection, although not applicable to many dermatologic conditions, has also found favor among dermatologists. In a recent paper Wile[3] stated that focal infection had passed from a "theory to a proved principle." If the term is accepted in its broadest sense, in addition to the group of proven conditions which Wile[3] mentions, there may also be included erythema multiforme and nodosum, alopecia areata, dermatitis herpetiformis, urticaria, and lupus erythematosus as due to or associated with focal infection. These conditions are seen not infrequently in general medical practice.

Erythema multiforme, as its name implies, is characterized by the development of bright red macules, papules, nodules, and vesicles having a symmetrical distribution and involving the hands, feet, arms, legs, face, and oral mucosa. The lesions develop rapidly, and involute in from two to three weeks. There is a tendency to repeated attacks.

[3] Wile, U. J.: Ann. Int. Med. 5:1103, 1932

Erythema nodosum commonly involves the extensor surfaces of the arms and legs, presenting as bright red, painful nodules. This condition is often accompanied by rheumatic pains and a slight rise in temperature. Senear[4] has observed an atypical case associated with an old hilus tuberculosis.

Alopecia areata most often involves the scalp, and in exceptional instances the beard, axillary, and pubic regions. The patches of baldness develop suddenly, are of irregular shape and size, and may coalesce. The bald plaques remain normal in appearance.

Dermatitis herpetiformis usually presents as symmetrical groups of papulo-vesicles, associated with marked itching. Variant forms, such as the bullous and pustular, have also been described. The process is further characterized by chronicity, a tendency to recurrence, and pigmentation of the areas involved.

Urticaria, with its whitish or pinkish wheals of varying sizes and shapes, is familiar to all. The lesions are associated with intense itching and burning, and in severe cases may become bullous or hemorrhagic.

As its name suggests, lupus erythematosus has long been considered a tuberculide, but as yet no evidence has been presented showing a direct relationship between this disease and tuberculous infection. Clinically, it presents as the circumscribed or disseminated variety, the former occurring more commonly is also less serious. The circumscribed variety involves by predilection the face and scalp, presenting as sharply marginated reddish patches. The lesions spread peripherally, are covered with a grayish tightly adherent scale, while the central portion presents atrophy and scarring. On the face it often takes a characteristic batwing configuration, extending over the nose on to both cheeks.

Deficiency Diseases

The deficiency diseases, such as diabetes, Addison's syndrome, pellagra, acrodynia, scurvy, and myxedema, are definitely morbid processes with deep-seated pathological changes, and yet all present cutaneous manifestations of helpful diagnostic value.

Furuncles and carbuncles are not uncommon in the diabetic patient, with gangrene in the more severe cases and the older patient. Rarely one sees a brown to gray pigmentation, together with increased pigment in the normally pigmented areas and an enlarged liver, to which the name bronze diabetes has been given.

Recently Wile[5] and his associates have devoted much study to the xanthomas. The lesions, which are due to the deranged fat metabolism occurring in diabetics, although sometimes having a gen-

[4] Senear, F. E.: Jour. Ind. State Med. Assoc., 23:1, 1930

[5] Wile, Eckstein, and Curtis: Arch. Derm. & Syph., 19:35, 1929.

eralized distribution, are located over the elbows, knees, hips, and buttocks. Their peculiar saffron color gives them a striking appearance. They are round or oval in outline and soft in consistency.

Brownish hyperpigmentation occurring in a band about the waistline, together with hyperpigmentation of the groins and axillae, weakness and loss of weight, is found in Addison's syndrome. In the advanced cases the tongue and buccal mucosa may also present pigmentation.

Pellagra, long considered a disease of the South, is seen not uncommonly throughout the state of Indiana. The chief features here are a dermatitis together with brownish pigmentation of the hands, feet, face, and neck. In addition there is an associated diarrhea and stomatitis, and in the advanced cases mental deterioration. Proper recognition of the cutaneous manifestations, which appear early in the disease, permit of successful treatment.

Acrodynia is considered by some the counterpart of pellagra, occurring in infants and young children. At first the child exhibits a marked irritability, and soon an intense redness of the palms and soles is noted. This may spread to involve the entire body. There is a marked photophobia, so that the affected child assumes a burrowing attitude to avoid the light.

The visible manifestations of scurvy, such as bleeding gums, together with painful joint movements, should prompt the examining physician to further investigation. X-ray of the bones and joints will present evidence which is diagnostic.

In myxedema we are confronted with a rather typical picture. The skin is dry, inelastic, and thickened. The features are smoothed out, and the hair is sparse and coarse. Further study reveals a lowered basal metabolic rate, and in some cases mental retardation.

Cancer of some internal organ involving the abdominal sympathetics, has been associated with pigmentation and hyperkeratosis involving by predilection the flexures. This is a striking picture, and gives to the skin of the involved areas a velvety appearance, to which the name acanthosis nigricans has been given.

This subject is one that could be enlarged upon to include many more conditions. I have tried to show you a few, which most often act as sign posts to the keen observer, pointing to the etiologic factor and urging him to search deeper in an effort to uncover the hidden pathologic process.

DISCUSSION

STANLEY CASEY, M. D., Huntington: My interest in dermatology is only that of a general practitioner of medicine, meaning that it is limited to the recognition and treatment of the simpler, more common skin diseases.

The appeal of this paper to me is not entirely in the different skin disease entities which he has so well described, but more particularly in the general theme of his discussion, namely, that the various manifestations of skin diseases are but an expression of disease conditions elsewhere in the body. To me this is a very logical explanation of skin diseases in general. The paper naturally presupposes general acceptance of the theory of focal infection as a cause of systemic disease. It links together general medicine and dermatology, and it emphasizes to the physician again the need for thoroughly physical examinations, because as Wile has said, "The skin is an excellent yardstick by which we can measure the general health of our patient."

Such a subject opens many avenues for discussion. We have only to mention a few: The cutaneous manifestations of carbohydrate intolerance; skin changes that go with endocrine disturbances; the changes that accompany hypertension and old age; and the skin as an indication of emotional changes—to realize that there are very few systemic disturbances into which the skin does not enter.

URINARY ANTISEPTICS*

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Frequently one hears the question asked, "What is a good urinary antiseptic?" It would seem that the answer is simple if one could believe the statements made by various detail men who call upon us and tell us of the efficiency of their own particular brand of urinary antiseptic. Certainly the answer is not so simple as it would seem after reading parts of a book published almost a hundred years ago, by a physician in this state.[1] In speaking of foul urine and urinary frequency he says, "You will also take twenty drops of the compound horsemint, three or four time a day in a little water, look for horsemint in the meteria medica, if in case there should be too free a portion of urine from the affects of the dose, a less portion should be taken, if there appears to be much pain about the kidneys take a half a teaspoonful of the tincture of cubebs with ten drops of laudanum three or four times a day, keep the bowels open with mild purgatives and nothing more is necessary; I have relieved hundreds of this disease with the above prescription; let the diet be light and cooling."

One is impressed by the quaintness of the language and the calm assurance of the doctor who wrote the above lines, and yet not much more than that which he advises was used during the next sixty years.

By urinary antiseptics we understand drugs which, given by mouth or intravenously, have the effect of killing bacteria in the urinary channels and thereby preventing or diminishing inflamma-

* Read before the Marion County Medical Society, December 20, 1932.

tion therein. The foregoing statement refers to drugs as stated when given by mouth or intravenously or, in other words, internal medication. There is a long list of drugs which are given externally by which we mean direct application of the drug to the urinary mucosa from the pelvis of the kidney to the external meatus of the urethra. We shall discuss only the better known drugs and shall first take up those used internally.

The search for an ideal urinary antiseptic has been a long one and has remained a vain one. It is true that the requirements are strict, but I believe each one is necessary. These requirements have been listed at various times and are summarized by Riaboff[2] "For the ideal urinary antiseptic Davis and White, and Leonard have enumerated seven requirements as follows: (a) Chemically stable; (b) non-toxic; (c) non-irritating to the urinary tract; (d) exert an antiseptic action in high dilution in urine of any reaction; (e) eliminated in high percentage by the kidneys; (f) eliminated in the urine in sufficient concentration to exert a local antiseptic action and at a rate by which *continuous* antiseptic action may be attained, and (g) administrable by mouth."

METHANAMINE

The drug was first prepared in 1860 by Butenow and introduced to the medical profession as a urinary antiseptic in 1890 by Nicolaier, who demonstrated formaldehyde in the urine as a split product of methanamine. This drug has held its own against many newcomers, but it was not until rather recent years that there was an understanding as to the proper method of giving it for the best results. Articles concerning methenamine, published about thirty-five years ago, quite generally advocated the giving of three grains of nutmeg with each dose, for it was thought that this had much to do with over-coming the bladder irritability which so frequently accompanied it. It was shown in 1912 by Burnam that methenamine in the test tube is without any antiseptic action, but formaldehyde on the other hand proved to be very germicidal. Therefore, it depends for its bactericidal effect on the liberation of formaldehyde in acid urine after its excretion by the renal epithelium. In administering urotropin it is necessary to give the patient sufficient acid sodium phosphate or sodium benzoate, usually five to ten grains in each dose, to maintain a marked acid reaction. Recently the efficiency of these acidifiers has been denied, and a better way is to administer ammonium chloride in the same dose. Our favorite way of giving methanamine is never less than 15 grains per dose, given at 9:00 a. m., 3:00 p. m., and 9:00 p. m., and the acidifier before or after meals. As a prophylactic, the drug is useful to prevent so-called urethral chill following the passage of a sound or cystoscope. It is very good in beginning pyelitis, but is without much value in pyelitis of long standing. It is a good remedy for pyelitis of pregnancy when diagnosed early on the appearance of bacteria and pus in the urine, and within the first few days after the temperature has risen. It is good antiseptic for tabetic patients depending upon a catheter to empty a paralyzed bladder. To list a few disadvantages of the drug—the formaldehyde excreted is sometimes very irritating and in some cases produces a nephritis with hematuria, and in others a chemical cystitis so severe that it must be discontinued. In many cases it will not sterilize the mucosa of the kidney pelvis or produce a sterile urine. Only too often hypertrophied prostates in the aged are irritated by its use. It should not be administered in the presence of hematuria, either macroscopic or microscopic. However, with all its disadvantages urotropin still remains the internal antiseptic of choice with the majority of urologists. The newer preparations of this drug in soluble form, ready for intravenous use, have been of some service. These drugs are cylotropin, a German preparation, and uritone, put up in ampules for intravenous use. The dose is thirty grains, given once daily, and is used particularly in severe cases of pyelonephritis. Due to the fact that methenamine is so quickly taken up when given by mouth and formalin so readily found in the urine after administration, the intravenous method has never become very popular.

MERCUROCHROME

This drug is said to be an efficient germicide in colon bacillus infection, whether used for instillations into the renal pelvis, for the bladder in urinary tract infections, or intravenously in colon bacillus septicemia. It is given intravenously in dosage of 4 mgm. per kilogram of body weight. It can be given by mouth as a urinary antiseptic, and it is found that most patients can tolerate as much as 900 to 1,200 mgm. of mercurochrome in salol-coated pills in the course of a day. I know that very extravagant claims for this drug are made by men of vast experience, but my own attempts to use it have not been so fortunate. Four years ago in the out-patient department at the City Hospital, in Indianapolis, I had the opportunity to give many intravenous injections of mercurochrome in cases of complicated gonorrhea. Our results were not satisfactory. Every possible precaution was taken to insure results according to the standards then used, but we thought our unfavorable reactions were too frequent to continue the intravenous use of the drug. In speaking of other dye products and empiric remedies, Keyes[3] rather curtly disposes of them in the following statement: "I feel confident that mercurochrome, pyridium, acriflavine and methylene-blue by mouth have no value beyond the impression they make on the patient's mind. If they did not color the patient's urine, they would not color his thoughts. If salol, the benzoates, the borates, etc., have any antiseptic value, it is so slight as to be negligible."

The foregoing statement was taken from the last edition of Keyes "Urology". I do not know that he has seen fit to change his statement by this time, but, after using "Pyridium" for about two years, I feel that we have a urinary antiseptic of some therapeutic value. "Four outstanding characteristics[2] have been ascribed to Pyridium, namely: (a) its marked power of stimulating the proliferation of epithelial cells; (b) a powerful bactericidal action directed chiefly against organisms of the coccoid type; (c) its ability to pentrate into the tissues and (d) its rapid elimination through the urinary tract. Pyridium should not be used in combination with any preparation containing mercury, or in uremia or in severe disorders of the kidneys of a non-infectious nature." In pyelitis of not too long standing it sometimes gives quick results. I have seen prompt relief secured in cases of complicated gonorrhea and in cases of persistent cloudy second urine.

Hexylresorcinal or Caprokol

In 1924 Veador Leonard[4] brought out a "synthetic compound possessing the experimental requirements of an ideal urinary antiseptic." There was much discussion and much written about this experimentally good drug. Unfortunately practice did not back up all of the experimental findings. The drug, Caprokol is given orally and it derives at least a part of its antiseptic effect from its power to reduce the surface tension of the urine. It is not influenced by acidity or alkalinity in general, but the administration of sodium bicarbonate does hinder its action. The water intake should be somewhat restricted while taking the drug. It must be given in capsules or emulsions. For ordinary colon bacillus infections, it must be given for from 30 to 90 days. Since 12 capsules are given daily and the capsules cost about $6.00 per hundred, one can readily see how the cost problem must enter into this prescription.

Neo-Arsphenamin

While it is not classed as a urinary antiseptic, neo-arsphenamin frequently is used in moderate doses, usually from .15 to .3 gm. being given every three to five days. It has found its chief use in the pyelitis of pregnancy and seems to be of great benefit in this type of case. Its beneficial results come from its ability to release formalin in the kidney pelvis and its use is attended with no bad after effects.

Drugs to Change the Reaction of the Urine

Eisendrath and Rolnick[5] call attention to the fact that "(a) bacillus coli is found in about 70 to 75% of all renal infections and (b) that certain strains grow most luxuriantly in an acid medium and others in an alkaline medium and (c) that the growth usually occurs when the H-Ion concentration is between 5.0 and 8.0. The lethal H-Ion concentration is 4.6 on the acid side and 9.5 on the alkaline side, but the renal tissues would be greatly damaged if an effort were made to acidify or alkalinize the urine to either of these extremes. Helmholz has shown that it is far easier to reach a concentration sufficient to inhibit the growth of B. coli on the alkaline than on the acid side. It has been the custom empirically to give acids and alkaline alternately. We now have a reason for such treatment based on laboratory research. The drug which has proved to be the best alkalinizer of the urine is potassium citrate, the minimum dose being 60 grains a day. The best acidifiers are acid sodium phosphate, 10 grains, 4 times a day; ammonium chloride, 10 grains, 4 times daily; and sodium benzoate in the same dosage." Much can be accomplished in the way of diet to change urine reactions. It is claimed[5] that "meat, eggs, and the grain products are notable acidifiers while other vegetables, chiefly the roots, are alkalinizers."

"Sansum, Blotherwick and Smith[6] have shown that certain foods, after ingestion, produce acidity in the blood while others produce alkalinity. They found that by feeding the basic diets to patients with hypertension with or without nephritis, they brought about a reduction of urinary acidity and much clinical improvement. The following tables taken from their reports are self explanatory:

Acidity of Certain Foods

"Bread, white, 2.7; Bread, whole wheat, 3.0; Dried sweet corn 5.95; crackers 7.81; eggs 11.1; egg white 5.24; egg yolk 26.69; fish, haddock, 16.07; fish, pike, 11.81; lean beef 13.91; chicken 17.01; lean pork 11.87; rabbit 14.8; veal 13.52; oysters 30; oatmeal 12.93; peanuts 3.9; rice 8.1.

Alkali Producing Foods

"Almonds 12.38; apples 3.76; bananas 5.56; dried beans 23.87; dried lima beans 41.65; beets 10.86; cabbage 4.34; carrots 10.82; cauliflower 5.33; celery 7.78; dried currants 5.97; lemons 5.45; lettuce 7.37; cow's milk 2.37; muskmelon 7.47; oranges 5.61; peaches 5.04; dried peas 7.07; potatoes 7.19; radishes 2.87; raisins 23.68; turnips 2.68."

Too much reliance cannot be placed upon the haphazard giving of certain foods to change the reaction of urine. I believe it is a good plan to keep the patient on a diet that is satisfactory without considering its acid or alkaline producing properties. With the administration of ammonium chloride in 10 grain doses four times daily, or sodium acid phosphate or sodium benzoate in similar doses we can keep the urine at a Ph of 5.5 or below by carefully watching and frequently testing the urine. A simple testing method is one in which the methyl-red paper is used. This particular paper does not show a change in color until the Ph has reached 5.5. When taken out of the container it is of a yellowish color and changes to deep red when placed in urine which has a Ph below 5.6. Ordinary litmus, of course, shows a

change at a Ph 7.0 or below. Helmholz[7] believes that when the methyl-red paper does not turn red, "administration of methenamine cannot be expected to give results." If this is true, one cannot help but wonder how much methenamine we have given to no purpose. It may account for the many cases in which we have religiously acidulated the urine and yet see no results from our careful medication.

Recently much has appeared in the literature concerning the ketogenic diet in the treatment of urinary infections. This diet depends upon excessive fat feeding and may prove dangerous by inducing marked acidosis. It remains to be seen if this diet treatment can be used safely outside of hospitals. The means so far employed of accurately testing the Ph is by the electric potentiometer. This obviously is not intended for use away from the hospital. In giving the ketogenic diet it is well to mention some points brought out by A. L. Clark[8] of the Mayo Clinic:

"1. The general condition of the patient must be such that he can endure the alteration in diet. A patient who is able to take a moderate amount of exercise is a far more satisfactory subject for this type of treatment than one who necessarily is confined to bed.

2. Cooperation of the patient is absolutely necessary.

3. The patient must be able to digest and assimilate fats.

4. If the infection is in the upper part of the urinary tract, treatment must be continued for a longer time than if the infection is in the bladder."

Something should be said about the volatile oils which have recently been scoffed at. Surely they do something to render the urine more soothing, and they may inhibit bacterial growth. There are many preparations which have been on the market for years. We prefer the santal oil in capsules of 5 to 10 minims, the Kava Santol Reidel (Gonosan) or the Santal Ava. Fluids must be restricted to get the maximum effect from these drugs, and they sometimes cause severe backache and disturb the digestion.

For many years we have employed the methylene blue compound of Lilly in the out-patient department of the Indianapolis City Hospital. While the laboratory reports show only a slight antiseptic action for either the santal oil or methylene blue, I feel that we see a decided benefit to patients (largely venereal) who come here and report prompt relief from urinary frequency and tenesmus.

Methylene blue was for a considerable time a standard remedy and almost all of the proprietary "kidney pills" contained it in varying amounts. It is interesting to find that B. A. Thomas[9], in a paper published in 1929, stated that the reason we did not get the beneficial results from this drug was because we did not use large enough doses. He claimed that 3 or 4 grains of methylene blue administered three times daily was therapeutically efficient, but that few patients can tolerate 12 grains of methylene blue daily for over a period of 7 to 10 days without developing vesicle and gastric symptoms.

The above list of urinary antiseptics, while it by no means includes all of those used, contains the principal ones. I am impressed by the fact that they are all notable for their drawbacks, and that we do not yet have the ideal antiseptic.

Local Urinary Antiseptics

Local urinary antiseptics include a very long list, and I shall only mention those with which I am most familiar.

1. *Silver Nitrate.*—This drug is used in all the specialties that have to do with mucous membranes. Kretschmer claims that for lavage of the renal pelvis it does all that is claimed for most antiseptics and does it better. It is used in the pelvis up to a 2% strength. In the bladder it is used in strength from 1:20,000 to 1:1,000. In the office, through the urethroscope, we use solutions of from ¼% to 40%. While it may not have strong germicidal properties, it is astringent and promotes local leucocytosis.

2. *Boric Acid.*—This, says Keyes, is the ideal solution to place in the hands of the ignorant patient for auto-lavage. The solution cannot be made too strong to do any harm, and is soothing to tender mucous membrances. It has very slight germicidal property.

3. *Argyrol.*—This drug is an albuminate of silver and is very generally used. It is frequently used for lavage of the kidney pelvis, not more than 4cc of a 5 to 10% solution being placed in the pelvis. We are all familiar with its use in 10 to 20% solutions for anterior urethral instillations in gonorrhea. Only freshly made solutions should be used.

4. *Albargin.*—Is used chiefly in anterior gonorrhea in the sub-acute stage and is rather penetrating. In Germany it is quite generally used for home injection in the strength of ½ to 1%.

5. *Protargol.*—This is perhaps the most generally used hand injection in this country. It is injected in ½ of 1% to 1% solutions two to four times daily into the anterior urethra. It is rather penetrating, and at first gives the impression of increasing the gonorrheal discharge due to the pronounced leucocytosis.

6. *Neo-Reargon.*—This is a new German preparation used in anterior urethritis and is given in the beginning in a 5% solution. Later the strength is reduced to 3%. I have found it most satisfactory in gonorrhea whether anterior or posterior. It is given twice to three times daily as an anterior instillation. It has the disadvantage of argyrol in being very mussy.

7. *Neosilvol* is another colloidal silver salt, much like argyrol, but of a lighter color. It is quite generally used, but I have found that probably due to its "sticky" character, it seems to promote folliculitis. It is also much used for pelvic lavage.

8. *Acriflavine.*—This dye is now made as neutral acri-flavine, and is supposed to be less irritating than formerly. I have had no recent experience with it. During the World War we were told of a wonderful new urinary antiseptic (Acri-flavine) and how it would revolutionize the treatment of lower tract urological infections. It has never seemed very good to me. Recently there has been a revival of the use of acriflavine (Boots) in acute anterior urethritis.[10] A few writers praise it highly, but also warn of the danger of stricture following its use for longer than a few days.

9. *Potassium Permanganate.*—This drug is quite generally used in irrigations of the bladder and urethra in solutions of 1:8,000 to 1:3,000. It gives rather soothing results, but is fairly dangerous in the hands of a novice for posterior irrigations. Its germicidal properties are very slight and I have always felt that the good it did was in proportion to the amount of heat that the patient could stand to be carried into the bladder and urethra.

10. *Mercurcochrome.*—This drug is used quite extensively in the anterior urethra. In my hands it has proved most useful in subacute urethritis and is used much as albargin is used. Its undesirable staining properties are a hindrance to home use.

11. *The Zinc Salts.*—These were used in great numbers in past years. They have the property of lessening an urethral discharge by putting a coating over the mucous membrane. Therein also lies their danger, as this coating also gives the patient a false sense of security. They are considered quite good medication in some of the non-specific urethral infections. They should never be used in treatment of specific urethritis.

12. *Metaphen.*—This preparation has been shown to be highly bactericidal, owing its properties to a linkage of the nitro-cresol group. It is used in two forms: (a) metaphen and (b) metaphen oil.

(a) Metaphen is most efficacious when used as pelvic lavage in cases of pyelitis in strengths varying from 1:8,000 to 1:5,000. The most remarkable results have been attained in pyelitis in children.

(b) Metaphen-in-oil is a pure olive oil solution containing the metaphen and is used most extensively as urethral instillations in all types of cases of urethritis. During the acute stages of urethritis the instillation should be preceded by a cleansing of the urethra in order to remove all debris and mucus. This may be attained by using either boric acid or weak potassium permanganate solution.

13. *Lunargen.*—This colloidal silver salt has much the appearance of argyrol and is used in the urethra in varying strengths up to 15%. Our results with this preparation have been very satisfying.

14. *Gentian Violet.*—This dye has been used successfully in anterior urethral infections of a non-specific nature. It is particularly effective where gram positive organisms are to be combated. Recently we have not used it very much.

In the above list I may have omitted a favorite local urinary antiseptic. As previously stated, I have included only those with which I am most familiar. I have come to believe that the topical application of medicines in the lower urinary tract is not so much a question of what kind of drug to use as it is a question of how to apply the drug. Within the past three years, I have been undecided as to which of three colloidal silver salts gave the best results in urethritis. Each of them acted satisfactorily but, regardless of the aplication, the gentleness of application, the cooperation of the patient, and the degree of immunity established by the patient were the deciding factors.

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SOME CAUSES OF BLOOD IN URINE*

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Blood in the urine, either gross or microscopic, should be considered a fire alarm and as such may point to a large or small fire, depending on whether the underlying pathology is serious or not. We all hear the patient say, "Give me something to stop it," or "It does not hurt and is getting less," or "It stopped before and will again," etc. However, we must make the patient realize that hematuria is often intermittent and without pain, though the cause may be serious, even fatal in time. Accordingly an early diagnosis, in order that treatment may be started before the condition has advanced to a more serious, or hopeless stage, is of the utmost importance. In the event that it is found to be of minor consequence, both physician and patient may be thankful and happy.

Eisendrath states that, "Ten percent of the lesions causing hematuria are of the structures

* Presented before the Third District Medical Society at Bedford, October 12, 1932.

adjacent to the urinary tract, that twenty percent are due to systemic causes, while the remaining seventy percent arise within the genito-urinary tract proper, two-thirds of which are upper tract." In considering these various phases, we must remember that more than one cause may exist at the same time.

Of the lesions adjacent to the urinary tract responsible for hematuria, we may name colitis, appendicitis and cholecystitis. In each case the infection is transmitted directly through the proximity of the structures and lymphatics, or by means of the blood stream to the kidney, causing a glomerulonephritis. A fourth example is menstrual hematuria, a form of vicarious menstruation.

Under the heading of systemic causes, we may list high protein diet, strenuous physical exertion, Bright's disease, hemophilia, erythemia, leukemia, angioneurosis, purpura hemorrhagica, scurvy and Hodgkin's disease. Subacute bacterial endocarditis shows blood in the urine at some time in most all cases. Some of the acute systemic diseases now and then accompanied by hematuria are typhoid fever, malaria, small pox and scarlet fever. Blood in the urine may also be caused by such drugs as urotropin, caprokol, turpentine, phenol, cantharides and quinine.

We are now ready to consider the largest group, that seventy percent of hematurias which arise within the genito-urinary tract itself. Inflammation, tumors and mechanical factors, in the order named, are the most common underlying causes, benign conditions often bleeding more than malignant ones. Usually, we find that frequency of the source increases as we ascend the urinary tract.

Beginning with the urethra, let us take up some conditions which with the history, location of pain, if any, and symptoms may help in making a diagnosis. In the urethral meatus of the female, an easily seen, small, red, almost pedunculated tumor, exquisitely tender, giving symptoms similar to cystitis, is likely a urethral caruncle, and may be cured by local excision, or fulguration with the electric current. In the male, palpation of a button like nodule in the anterior urethra, with blood cells in the urine, or a slightly bloody discharge, makes one suspicious of an intraurethral chancre. Urethral stricture as a source of blood in either sex may be diagnosed and treated by passage of bougies or sounds.

Bleeding in the anterior urethra of the male from any cause may show between urinations. Hematuria accompanying gonorrhoea may be from the anterior or posterior urethra and prostate. The three glass test, made by having the patient void into three successive glasses, may help in locating the source. More blood in the first glass points to the anterior urethra. Blood from the posterior urethra may be signified by a terminal hematuria, or blood in the third glass, and designates bladder neck and prostate. If bleeding from this source is copious there may be blood in the first and third glass, with the second practically clear. An even amount of blood in all three glasses points to bladder or kidneys, unless there is residual when it may be from the bladder, but never from the urethra. Terminal hematuria between the ages of fifteen and twenty-five is usually due to tuberculosis or sexual strain. Ruptured urethra, resulting usually from perineal injury, is nearly always accompanied by bleeding, and must be watched closely for extravasation and infiltration.

Prostatic calculi, while not common, are a cause of hemorrhage and may sometimes be recognized by crepitus or hard lumps in the lateral lobes. Nodules in the prostate due to early carcinoma are usually at the apex of the gland. In youth, nodules in the same location are probably tuberculous. Carcinoma of the prostate is accompanied by blood about one-fifth of the time. Contrary to general opinion, blood is associated still more frequently with benign hypertrophy of the prostate. In differentiation, sciatic and pelvic pain in an old man, with bone-like hardness and fixation of the entire gland including the seminal vesicles, is almost pathognomonic of malignancy.

In the bladder itself any infection may be so severe as to cause hematuria in addition to the symptoms of cystitis.

Bladder stone bleeding is chiefly terminal and may often be diagnosed from the sensation given when a sound passed through the urethra strikes against the stone. Occasionally, the patients will say that they feel something roll about in the bladder. Rest, flat on the back, tends to relieve the distress and frequency of urination. Exertion aggravates the symptoms and, as time goes on, a constant aching spasm or strangury sets in. Between the ages of twenty-five and forty-five, stone, as the cause of hematuria, increases, while tuberculosis decreases.

Tumors of the bladder cause hematuria as their first symptoms, though it is not an early one, in about seventy-five percent of cases. In the remaining twenty-five percent, the first symptoms are painful urination, frequency, cystitis, a partial or complete retention, or some type of bladder discomfort. Severe bladder hemorrhage from thirty-five to fifty is most likely due to tumor. In malignancy, foul, ill-smelling urine is common, and bimanual pelvic examination may disclose an infiltrating hard mass in the bladder wall. Bleeding is more common in the benign papillomatous growths than in the malignant ones. Some help may be obtained from the age incidence, Geharty stating that sixty-eight percent of carcinomas are between the ages of fifty and seventy, while seventy-eight percent of papillomas are between the ages of thirty and sixty. Early diagnosis may prevent a malignancy, since all papillomas are potentially malignant.

In fracture of the bony pelvis, bloody urine is pretty sure to mean ruptured or punctured blad-

der, and calls for early operation and bladder drainage. Delay is usually fatal to these patients.

Tuberculosis of the urinary tract may be suspected from the history and physical findings, and often proved by finding tuberculosis bacilli in the urine on making the acid fast stain. Here I would like to digress to say that a urine which persistently shows pus, without the presence of either blood or pyogenic bacteria, frequently harbors tuberculosis bacilli. Frequent and painful urination, hematuria complete or terminal, with sometimes a partial incontinence, are common in tuberculous ulcers of the bladder. In renal tuberculosis the bleeding may be so free as to clot in the bladder. In this respect it resembles bleeding of kidney tumor. In differentiation, hematuria from tuberculosis usually begins between the ages of fifteen and thirty-five, and, therefore, falls between the two periods when bleeding from kidney tumor prevails. Bleeding alone in tuberculosis is an early symptom, while enlarged kidney is a late one.

Kidney tumors, while of different types, are similar in that painless hematuria is the initial symptom in practically all of them. They are most common in early childhood, and between the ages of forty and sixty. The bleeding is spontaneous and profuse. It stops as readily as it starts, only to repeat at closer intervals as the tumor enlarges. Next comes pain in the loin, followed by a palpable tumor, which is a late finding. The most common kidney tumor of adult life is the hypernephroma. All but polycystic kidney, which is bilateral, call for nephrectomy. In this type the cysts may be recognizable through the abdominal wall.

A loose kidney, with or without hydronephrosis, which has become acutely congested, as a result of back pressure from kinked ureter, causes hematuria in about ten percent of cases. Ureteritis, pyelitis and parenchymal kidney infections are additional causes of bleeding. Ruptured kidney, usually due to injury over the loin, gives hematuria in about eighty percent of cases. This condition, like rupture of the urethra or bladder, demands close attention and often surgery.

Kidney stones at some time or other cause blood in the urine in about forty percent of cases. While ureteral stone usually manifests itself by severe pain radiating into the groin, urethra, labia or testicle and inner side of thigh, kidney stones give no pain in about thirty percent of cases. These so called silent calculi at times become so large before discovery that the kidney is destroyed.

Essential renal hematuria is now thought to be due to some of the more obscure causes, and usually can be explained if diligent search is made. Some of the more rare explanations are angioneurotic renal hemorrhage, papillitis, angioma and hemorrhagic nephritis. According to Keyes, there are some cases for which we cannot find a cause, and must group them under that title which confesses our ignorance, "Idiopathic renal hematuria."

From the foregoing discussion, it is evident that many causes of blood in the urine cannot be diagnosed by the methods ordinarily at hand. We may first turn to X-ray, which will diagnose most stones, occasionally a kidney tumor, and those late cases of prostatic malignancy, with metastasis to the bony pelvis. A cystogram will diagnose some bladder tumors. Intravenous pyelography will be found of value in a portion of the following types of cases, kidney tumors, hydronephrosis, kink and stricture of the ureter, bladder tumor and tuberculosis of the kidney. I say a portion for two reasons: first, the pathology may not be advanced enough to be found by this method alone; and second, the medium is not always eliminated in sufficient concentration to visualize the existing condition.

Cystoscopy is the most accurate method we have. This permits us to visualize in the lower tract any pathology and its degree of development. In addition, if bleeding is present at the time, diagnosis is simplified, especially if it is coming from a kidney, for we can see the bloody urine spurting from the ureteral orifice on the involved side, which narrows down the field of examination. Bilateral kidney catheterization, which permits collection of segregated urine from each kidney for analysis and culture, and differential kidney function tests, with radiography and pyelography completes the examination.

In conclusion, the causes of blood in the urine should be considered of such importance that, in assuming responsibility for these patients, we must insist upon the right to urge that all available methods at our disposal be employed until a definite diagnosis is made.

URINARY CALCULI *

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In preparing this paper on urinary calculi I was particularly impressed with the voluminous literature on the subject and I have selected two phases of the subject that seemed to me to be of considerable interest: history and etiology.

Stone has always received full recognition by the practitioners of medicine and an examination of the earliest medical literature shows the symptoms were fairly accurately described even then. The clinical picture remained the same for many centuries, and only in the last fifty years does one find a great change, chiefly because the character of the disease itself is altering. Countries where it was formerly a scourge are now almost immune from it. The age incident is also changing. The disease varies in different countries and stone in India presents problems which are very different from those found in America. With the advent of

* Read before Marion County Medical Society, December 20, 1932.

the cystoscope and radiography our methods of investigation have been entirely revolutionized and an operation for stone in the urinary tract is no longer exploratory, but the location, size and shape of the stone is fairly accurately known before the operation is attempted.

Joly[1] says that the earliest specimen of stone that he knows of was discovered by Professor Elliott Smith in the grave of a predynastic and prehistoric Egyptian. He considered it to have been several centuries prior to Mena, the first King of Egypt, who reigned somewhere between 4800 and 4500 B. C. The calculus must therefore be about 7,000 years old at the present time. It was discovered in the pelvis of the skeleton of a boy about fifteen years of age. The stone is of yellow color, distinctly laminated, and is composed of a central nucleus of uric acid, surrounded by a thick layer composed of calcium oxalate and ammonium magnesium phosphate. There was no evidence that it was formed around the ova of the Bilharzia and seemed to be a primary uric acid stone with a secondary coating of phosphatic material.

The ancient Hindoos of India were skilled surgeons. Susrusta describes 121 surgical instruments, twenty of which were cutting. More remarkable still is the fact that the operation of supra-pubic lithotomy was described in the Ayur-Veda. The exact date of this Veda is not known but it was somewhere about the commencement of the Christion era,[1] so that the Indians anticipated Franco, Douglas & Cheseldon by more than 1500 years. The ancient Indian surgeons were scrupulously clean and devoted great attention to details. They trained their students by making them practice surgical procedures on the leaves and stocks of plants. When they were proficient they were allowed to operate on the bodies of animals.

Hippocrates (460-370 B. C.) recognized both renal and vesicle calculus. He described four diseases of the kidney, the first of which was a renal colic. "An acute pain was felt in the kidney, the loins, the flank and the testicle on the same side. The patient passes urine often, little by little, the urine is suppressed. Some gravel is passed with the urine. When this gravel passes down the ureter, it causes severe pain which ceases when it is expelled."

Hippocrates was a daring surgeon and opened the kidney when it was pyonephrotic, though he does not appear to have removed renal calculi. It is difficult to understand why he forbade his followers to operate for stone in the bladder, "Neither will I cut them that have stone, but will leave this operation to those who are accustomed to perform it," occurs in the famous Hippocratic Oath.

THE LITHOTOMISTS

In the days of Hippocrates the surgery of stone seems to have been in the hands of itinerant lithotomists. Their existence has been argued from the passage of the Hippocratic Oath relating to stone[1]. The history of medicine in both India and Greece would tend to show that itinerant stone cutters flourished from the earliest times. After the fall of Rome, medical science sank to a very low ebb, and the standards of these strollers was correspondingly debased. It is interesting to note that their efficiency appears to have run a course parallel with that of the recognized medical profession. In the dark ages it was probably exceedingly low, but as the Renaissance dawned it began to improve and this progress was maintained until the 18th century, when all prejudices against treating calculous disease was finally broken down and the need for traveling stone cutters was, in consequence, no longer felt. They could only exist as long as the regular profession neglected the surgery of stone.

We have no accurate details as to the type of operation performed by the earlier strollers, but it was most probably similar to that described by Celsus, i. e., perennial lithotomy without a staff[1].

It is only in the beginning of the sixteenth century that we find any mention of the grand Appareil, i. e., lithotomy with a staff described by Marianus Sanctus in his book Libellus Aureus.

The family of Collots were expert lithotomists for eight generations and handed down their closely guarded secrets from father to son. Laurent Collot was Royal Lithotomist to Henry II, Francis II, and Charles IX. One of the Collots operated on Louis XV for stone in 1754[1]. It is said that the monarch insisted that one of his courtiers, who also suffered stone, should first undergo the operation as a sort of trial trip.

There were many noted lithotomists during the sixteenth, seventeenth and eighteenth centuries, both strollers and among the regular profession. During the eighteenth century stone appears to have been exceedingly common in most European countries. Special hospitals were erected for its treatment in France, Holland and elsewhere. It was also very common in England. Sydenham suffered from stone[1]. Horace Walpole also had vesicle calculi. England, Holland, France, and parts of Germany were vast "stone areas," resembling the stone area in India of today.

It is no wonder that quack remedies, stone solvents or lithotriptics had a great vogue. The operation performed without an anesthetic must have been a ghastly affair. Ambrose Pare stated that four strong assistants were necessary and strength, not skill, was the essential qualification. One cannot blame patients for shrinking with horror from such an ordeal and trying by every possible means to avoid an operation. Also we must remember most physicians believed in lithotriptics and considered them to be efficacious. There was no other way of dealing with stone in the kidney.

These lithotriptics may be divided into two classes. The first were remedies which were

[1] Stone and Calculous Disease of the Urinary Organs. J. Swift Joly.

honestly thought to be effective and were prescribed by the most distinguished physicians of the day; the second were either quack remedies or were of the nature of amulets or talismans. Some of the first were so extraordinary that it is hard to imagine how they ever could have been advocated.

In the early Hindu medical literature[1] we find many prescriptions for dissolving stone; for example, a mixture of butter, pepper and ginger, to which is added, drop by drop, the urine of sheep. Theodosius Priscianus recommended the injection of hare's kidney as a remedy for renal lithiasis. (He seems to be the originator of organotheraphy.)

The influence of astrology is reflected in the composition of many of these lithotriptics. In Chaucer's time, it was believed that a lion engraved in gold, made when the sun was in Leo and the moon had no aspect towards Saturn, was a preventive against stone. One of the most notorious of all the stone solvents was the quack remedy of Joanna Stevens which was actually purchased by an Act of the English Parliament[1] in order that it might be made public. The sum paid for it was 5,000 pounds and when the prescription for it was published in the London *Gazette* of June 19, 1739, the ingredients proved to be powder of old tobacco pipes (clay), egg-shells, snail shells, soap, white onion, saxifrage, burdock, seeds; hips and haws, and a few other common vegetable extracts. Surprising as it may seem Sydenham used this remedy himself and declared he received much benefit from it.

Nephrolithiasis

Although this disease was known from the earliest times and Hippocrates gives a good clinical description of it under the heading of "The first disease of the kidneys," yet it is doubtful if it was ever operated upon. There are numerous fanciful stories and legends with regard to nephrolithiasis in the early literature but nothing definite or authoritative until 1880, when Morris first performed a nephrolithotomy. The first positive x-ray diagnosis of a renal calculus was made by MacIntyre in 1896. Plate exposure was 12 minutes and findings were verified by operation.

During the last few years of the eighteenth and the early part of the nineteenth century, great advances were made in the chemistry of urinary substances. Urea was discovered in 1773[2]. Uric acid was first isolated from the urine in 1776 and found in urinary concretion in 1797. The phosphate had previously been discovered by the alchemists and these discoveries stimulated attempts to dissolve stones by injections into the bladder. A large number of substances ranging from gastric juices and dilute nitric acid to salts of the alkali metals were employed but it soon became obvious that any agent that was strong enough to dissolve the stone was injurious to the bladder wall.

In 1832, Heurteloup designed an instrument with parallel blades resembling those of a modern lithotrite but without any screw mechanism. A short time later, Birmingham developed the screw mechanism in use in lithotrites today.

In 1846, Sir Philip Crampton[2], of Dublin, introduced the first suction apparatus for the removal of stone fragments from the bladder after the stone had been crushed.

Etiology of Stone

In order to save repetition we will discuss the whole subject of stone formation in the urinary tract, it being understood that the principle is the same no matter what portion of the tract is involved. The formation of calculi has been a debatable question for many years. Authorities agree that there are many factors that enter into the formation of stone. Joly[1] says, "Urinary calculi, and indeed all calculi, are formed of two distinct types of substances; the crystalline and colloids." As both crystals and colloids enter into the composition of all true calculi, it may be assumed that both these substances are necessary for the formation of ordinary stone. One is, therefore, tempted to define a calculus as a concretion formed of urinary crystals, bound together by colloid substance. In this conception of stone formation, the crystals may be compared to the bricks of which a house is built while the colloid is the mortar which holds them together.

Young[2] says, "To understand the peculiar circumstances which surround the formation of calculus, we must consider the chemical aspects of the urine." Among the substances which the kidney is called upon to excrete are some which are very slightly soluble in water which is the urinary solvent. In this class, the principal examples are uric acid and calcium oxalate. Other urinary constituents are somewhat more soluble as the urates with carbonates and phosphates following in ascending order, while such substances as urea, creatinin, and sodium chloride are extremely soluble. Every one has noticed that not infrequently the voided urine contains a sediment composed of tiny crystals of uric acid, calcium oxalate or the various phosphates, already precipitated. Yet many of these cases never show the slightest tendency towards stone formation. It is evident that a change in the urine that brings about a precipitation of such substances is not sufficient to cause the particles to cohere in the form of a stone. What conditions are necessary for this? A great many theories have been put forward. Most of them have started with the idea that many substances exist in the urine in the form of super-saturated solutions. This phenomenon can be observed in simple watery solutions and it is characteristic of it that if a small crystal of the substances in solution be inserted, it will immediately begin to grow by the deposition on it of that portion of the dissolved substance which is in excess over the true solubility. Upon this assumption, therefore, it has

[2] Young's Practice of Urology.

been thought that the existence of a nucleus is necessary for the formation of stone. Acting on this hint, various investigators have found bacteria in the central portions of urinary calculi. It has, therefore, been put forward that clumps of bacteria, bits of mucus, muco-pus, or desquamated epithelium—in general, products of an inflammatory reaction, are the nuclei of all urinary stones not due to foreign bodies.

These theories[2] are by no means satisfactory. They hold out little promise of practical therapy. Certain facts appear to be incompatible with them. In many stones it has been impossible to demonstrate any such nucleus. Many cases of extensive inflammation of portions of the urinary tract exist without any tendency to stone formation. Nuclei exist plentifully in many essentially normal patients, as desquamated epithelium cells, precipitated particles, or crystals of urinary constituents, or in case of mild renal disease, urinary casts without any tendency to stone formation.

Carnivorous animals show little tendency to stone formation, although their urine is habitually very concentrated. Pieces of urinary calculi placed in the kidney pelvis of dogs do not grow, but may even decrease in size. In an effort to answer the many questions raised by these various observations, the physical chemists have devoted much thought to the problem, but I shall not try to enumerate them and their various findings here.

Geographical Distribution

Joly[1] says that all that we can say is that lithiasis is more usual in the old world than in the new and that the three most important stone areas, viz:, India, Mesopotamia, and South China, are the districts where civilization has existed from the dawn of history and where defective sanitation and hygiene are still the rule.

Careful investigation of statistics fails to show a hereditary tendency in the formation of urinary calculi.

Chronic Infection

There is a considerable amount of evidence to show that chronic foci of infection may predispose the patient to stone. Rosenow and Meisser[3] show that by devitalizing certain teeth in their experimental animals and after filling the pulp cavity with micro-organisms from cases of nephrolithiasis, and sealing off these cavities, calculi were formed.

Influence of Diet

In 1917 Osborne and Mendal[4] showed that their experimental animals were prone to develop calculi if allowed to go for some time without an adequate source of the fat soluble vitamin. McCarrison[5] after several years of experimenting on albino rats, states that it leaves little room for doubt that in albino rats urinary calculus is a disease of faulty nutrition. These factors are of two orders, those of deficiency, and those of excess of certain food constituents. The former are negative and the latter positive factors. The negative factors so far found are deficiency of fat soluble vitamins and deficiency of phosphates. The positive factors are excess of lime, and some unknown agent present in varying amounts in different cereal grains.

Autopsy on 844 well fed albino rats living under conditions of perfect sanitation failed to show calculi. In 844 deficiently fed rats there were 205 cases of stone.

S. Ranganathan[6] reports chemical analysis of 78 urinary stones produced by McCarrison in albino rats by deficient diet shows a close relation between the diet and the chemical composition of the stones. Stones rich in calcium were produced on diet to which extra lime was added.

In recent conversation with Dr. Edwin C. Court, a medical missionary in Siam, he said that stone is one of their most serious problems. Children are especially prone to have stone. The natives of North Siam whose diet consists almost exclusively of cereals are often affected, while those living in South Siam along the sea coast where sea food is plentiful, are fairly free from stone.

In conclusion, if urinary calculi are due to faulty nutrition it would seem but a simple matter to eliminate this most serious condition, but much study and research must yet be done before the question can be definitely decided.

[3] Rosenow and Meisser: Collected Papers from the Mayo Clinic, Vol. 13, page 253.

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"THREE GENERATIONS OF IMBECILES ARE ENOUGH"

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This is a period rife with taxation controversy, a time when tolerant and willing citizens are paying and paying until thousands of their homes are actually "slipping" from them, and a time when one of the most unselfish and diligent legislative bodies that ever convened in Indiana is making uprecedented effort to effect an economical equilibrium. Certainly an organization so civicly influential as the Indiana State Medical Association, possessing special insight into the broad fundamentals of public health, and not only peculiarly empowered to wield but entrusted to guard the destiny of the public's physical welfare, must hold not as its sacred privilege but as its moral and patriotic duty the immediate and thorough acquainting of every citizen in the state of the rapidly increasing social menace and burden of the "unfit."

The proximity and gravity of this imperiling hazard is best and unquestionably shown by the following concrete facts derived largely from data

gathered from recent annual reports of various state departments to the governor:

1. The "meek and lowly" are absorbing nearly one-half the time, money, and energy of our population, and are leaving but little for culture or racial advancement, or the care of more worthy handicapped citizens, such as our deserving poor and aged.

2. Our growing population is being increasingly maintained by the moron group.

3. Families of the upper strata are forced to limit their own number of off-spring because of the social burden of the "undesirables." (The moron family is more than treble that of the physician.)

4. Feeblemindedness prevails in large percentages in all benevolent and penal institutions, and produces more pauperism, degeneracy, and crime than any other force.

5. The moron, the most prolific and deprecating of the feebleminded, is at large to the estimated extent of over 45,000.

6. Most of our institutions for delinquents are over-crowded seriously and are rapidly becoming more so.

7. Crime owes much of its increasing burden (now approximating $5.00 per capita of the general population) to underlying mental defectiveness.

8. Our twenty state institutions for the "undesirables" represent twice the financial outlay as our four state institutions of higher learning. The annual maintenance cost of the former exceeds that of the latter.

9. The number of insane in the state is equal to the total enrollment of both state universities.

10. The total number of delinquents in all state and county institutions equals the combined enrollment of all our thirty-two colleges and universities.

11. It is well indicated that more children who leave our schools will eventually enter our mental hospitals than will graduate from our schools of higher learning.

12. Files of our Board of State Charities contain hundreds of family records where practically every family member is now spending, or has spent, part or most of his life in one or more of our benevolent or correctional institutions.

13. Since the re-enactment of the sterilization law in 1927, less than 100 eugenic sterilizations have been recorded in our twenty institutions. This is in great contrast to the 236 performed during an equal period of time by one physician in a single institution prior to the passage of our first law in 1907.

14. We physicians with improving skill, assisted by increasing state and private charity, are more and more enabling the "weaklings" to survive and propagate their kind.

These facts react appallingly upon all public-spirited individuals and public tax-payers, and impel but one response, namely, the propagation of the "unfit" must be checked.

No group of citizens understands better than we physicians the unrelenting "workings" of the basic agent, heredity. None know better than we that the most immediate and effective method of prevention in dealing with this public health problem is sterilization. We hold the procedure fully as applicable as vaccination for smallpox or diphtheria. By simple vasectomy or salpingectomy the individual is deprived of no hormone, secretion, organ, or sex pleasure, the only change being inability to procreate. The exception would be in the instance of severe criminals such as the killer type in which case it might be desirable to obtain a "submissive effect" (an effect familiar to every farmer boy.) In this event the sterilization would be extended to include castration.

By familiarizing our citizens with the existing load of the "unfit," and the dual merit of eugenic sterilization, primarily guaranteeing increased social progress and happiness to the future generations, and lessening taxation upon the present generation by releasing to self-support a large per cent of those incarcerated, we will unleash an impetus from public opinion that will quickly activate our practically dormant sterilization laws. *We will thereby assist society in its present embarrassment by directing it from the erroneous policy of building additional asylums, enlarging penitentiaries, and increasing millions to contribution.*

Our responsibility in this cause is most pertinent. Through our state-wide organization with its county units the dissemination of such information would be a very short and minor task. We then could follow with further leadership, and in the end in addition to rendering a most constructive and distinctive service, would stimulate the government to emphasize less the importance of policing and tax-collecting, and to concentrate more upon the progressive function of guarding the intrinsic welfare of its people.

PROCEDURE PHYSICIANS SHOULD FOLLOW IN MAKING INCOME TAX REPORTS*

Collectors of Internal Revenue have mailed to all taxpayers of record, blanks for making federal income tax returns for the calendar year 1932.

These blanks must be filed with collectors on or before March 15, 1933, and should be made in accordance with and pursuant to the Revenue Act of 1932, enacted last June by Congress and which differs in many respects from the Revenue Act of 1928 used as the basis for returns filed last year.

* Reprinted from the *Ohio Medical Journal*, February, 1933.

Failure to receive a blank does not relieve a physician of the responsibility to file a return on or before March 15, 1933. If blanks are not received by a physician who is required by the Revenue Act of 1932 to file a return, he should apply at the internal revenue office of the district in which he resides. These districts, with the name and address of collectors, are appended to this article.

Among the important changes in the income tax procedure imposed by the Revenue Act of 1932 are:

(1) Increase in the rates of taxation.

(2) Decrease in the personal exemptions.

(3) Elimination of the earned income credit, meaning that all taxable income, whether earned income or income from other sources, is subject to the same rate of taxation.

(4) New schedule of surtax rates on net incomes, beginning with net incomes in excess of $6,000 instead of $10,000, the minimum provided in the Revenue Act of 1928.

(5) Drastic limitation of losses on sale or exchange of stocks and bonds held for two years or less.

Physicians making returns on income for the year 1932 should compute their normal tax on the following basis:

First $4,000 over the personal exemption and credits is taxed at 4%; the remainder at 8%.

Personal exemptions, which are credits against net income for the purpose of computing the normal tax but not the surtax, are listed as follows: $2,500 if married and living with wife, or if head of a family; $1,000 if single and not head of family; $400 credit for each dependent under 18 years of age or physically or mentally handicapped dependent.

The surtax rates for individuals will be explained in the following detailed analysis of the procedure physicians should follow in filling out blanks for 1932 income:

Those Who Must File Returns

Every physician whose net income for 1932 was $1,000 or more, if single, and $2,500 or more, if married or the head of a family, must file an income tax return with the Collector of Internal Revenue of his district on or before March 15, 1933. He also must file a return if his gross income was $5,000 or more, irrespective of marital status and irrespective of net income.

All physicians and other professional men are required to use Form 1040 in submitting their return, regardless of the amount of net income. All groups, joint ventures and other incorporated organizations are regarded under the Revenue Act of 1932 as partnerships and must file partnership information returns, the members of such groups to report their distributive shares as their own income.

Gross Income

Gross income includes gains made from professional services, business activities, certain forms of dividends and interest, bad debts charged off in previous years but since collected, bonuses received as compensation, partnership profits, profits from the sale or exchange of real estate, rents and royalties, and funds received from other sources.

Personal Exemptions

If married and living with wife, or the head of a family, for the entire year, an exemption of $2,500 is allowed; if single and not a head of a family, an exemption of $1,000 is permitted. Credit of $400 is permitted for each dependent under 18 years of age or each physically or mentally handicapped dependent regardless of age. The credit is not allowed in the case of a dependent minor over 18 years of age, even if such minor is attending school. In case of a change during the calendar year of the status of the physician in so far as it affects the personal exemption or credit for dependents, the personal exemption and credit should be apportioned in accordance with the number of months before and after such change. Authority for prescribing rules and regulations for such apportionment was given to the Commissioner of Internal Revenue.

Items Not Reportable as Income

The following items should not be included in gross income since they are exempt to income tax:

Cash or value of property acquired by gift, bequest or inheritance (income from such property is taxable, however); insurance proceeds; damages received in personal actions; dividends on stock of Federal Reserve Banks, land banks, and intermediate credit banks; dividends from corporate earning accumulated prior to March 1, 1913; state jury court fees; state court receivership fees; stock dividends and rights; interest received from the obligations of state or political subdivisions thereof; interest from securities issued under the Farm Loan Act; interest on Liberty 3½% Bonds and U. S. Bonds issued priod to September 1, 1917, and interest on the obligations of the possessions of the United States.

Interest received on Liberty 4% and 4½% Bonds and certain other U. S. obligations is exempt if the total holdings are not in excess of $5,000. Interest received from U. S. Treasury Notes *is reportable* as income. However, interest from these sources is subject only to surtax since it is deductible as credit from gross income in computing net income.

It will be noted that the Revenue Act of 1932 does *not* exempt from income tax, allowances received under the provisions of the War Risk Insurance, Vocational Rehabilitation and World War Veterans' acts, and pensions received from a State or the United States.

Moreover, it does *not* allow the previously specified $300 exemption in reporting dividends or interest from building and loan associations.

DEDUCTIBLE ITEMS

In computing net income, the following items may be deducted from gross income:

OFFICE RENTAL—If a physician pays rent to another person for office space, he may deduct the amount. However, if he owns his own home and maintains an office in it, he *cannot* claim deduction for office rent.

AUTOMOBILE—The cost of repair and upkeep of an automobile used in professional visits may be deducted. That part of the salary paid to a chauffeur and attributable to time spent in driving his employer on professional calls, may be deducted. Sums spent for taxi hire, car fare, etc., while on professional calls, may be deducted.

Loss on an automobile used in professional business through depreciation may be deducted. The depreciation which should be deducted annually is figured by dividing the cost price of the machine by the number of years of its usefulness.

If a physician has one automobile which is used exclusively in professional business, he may deduct the full depreciation each year. If the machine is used only partly in professional business, the deductible depreciation should be computed on the basis of the amount of time the car is used for professional purposes.

If a physician possesses two cars, each of which is used partly in professional business, the deductible depreciation on each car should be computed on the basis of the amount of time each car is used for professional purposes.

In other words if an automobile is used only partly for business purpose, depreciation may be deducted only on a proportionate part thereof, the amount of depreciation depending on the amount of time the machine is used in professional business.

PROFESSIONAL DUES—Dues paid to professional associations to which, in the interest of his profession, the physician belongs are exempt and may be deducted. Expenses incurred in taking graduate courses have been held *not* to be deductible.

TRAVELING EXPENSES—Traveling expenses incurred by a physician in attending medical conventions of organizations of which he is a member are deductible from gross income.

SALARIES AND WAGES—Deductions are permitted for the salaries of nurses, laboratory workers, technicians, assistants, stenographers or other clerical workers in a physician's office so long as their duties are connected with professional work. Wages paid maids for services rendered in connection with professional practice also are deductible.

MEDICINES, INSTRUMENTS, ETC.—Cost of medicines, used in the office to treat patients, medicine dispensed, bandages, laboratory materials and all other supplies necessary to operate the office may be deducted. One-fifth of the purchase price of surgical instruments may be deducted annually for five years under a depreciation account. All office fixtures, appliances, etc., used in office or laboratory may be depreciated annually, according to the estimated life of their usefulness. The customary depreciation for office fixtures and furnishings is 10% annually.

GENERAL OFFICE EXPENSE—The cost of telephone, telegrams, etc., used in professional services may be deducted. Expenditures for heat, light, water, etc., in the office are deductible.

LIBRARY—The original cost of medical books may be depreciated 10% annually, since the life of these is usually considered 10 years.

DEBTS—If the physician's books are kept according to the "Cash Receipts and Disbursement" system, he may not charge off any unpaid debt because he is then only reporting as gross income those accounts which have proved to be good. Bad accounts have not been reported and are therefore not deductible.

If books are kept on an "Accrual Basis" (where expense is actually incurred and payable even though not yet paid, or income earned although not yet collected), it is permissible to charge off all debts which have been definitely ascertained to be worthless during the fiscal year covered by the report.

The physician must be careful, however, to include in gross income bad debts which have been charged off in previous years but collected during the calendar year for which the return is filed.

TAXES AND LICENSES—Any tax paid upon materials required in professional work are exempt. All license fees which physicians are required to pay are deductible items. This includes the narcotic tax, automobile license, local occupational taxes, taxes on club dues, etc. All taxes paid upon real or personal property, whether the property is used for business or otherwise and all interest paid upon indebtedness (except interest paid to carry nontaxable securities) are deductible. The Ohio Gasoline Tax has been held as *not* deductible.

Federal taxes upon checks, electrical energy, safety deposit box rentals, and use of communication facilities are deductible.

LOSSES BY FIRE AND THEFT—Loss of and damage to a physician's equipment by fire, theft, or other cause, not compensable by insurance or otherwise recoverable, may be computed as a business expense, and is deductible, provided evidence of such loss or damage can be produced. Such loss or damage is deductible, however, only to the extent to which it has not been made good by repair and the cost of the repair claimed as a deduction.

INSURANCE PREMIUMS—Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries to

a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment, and damage to or loss of professional equipment by fire or otherwise. Premiums paid on life insurance are *not* deductible nor is interest on indebtedness incurred in connection with the purchase or carrying of annuities.

LEGAL EXPENSE—Expense incurred in the defense of a suit for alleged malpractice is deductible as business expense. However, expense incurred in the defense of a criminal action is *not* deductible.

CONTRIBUTIONS—It is permissible to deduct from gross income contributions when made to charitable, religious, educational and scientific organizations, to an amount not to exceed 15% of the net income, exclusive of such contributions.

NORMAL TAX RATE

As explained previously, the normal tax rate on 1932 income is 4% on the first $4,000 in excess of exemptions and credits and 8% on the remainder of such excess.

ABSTRACTS

JERUSALEM ARTICHOKES

Recognizing that people at present are diet minded, many advertisers are concentrating on the promotion of foods. Among other items is the jerusalem artichoke. The *Pittsburgh Medical Bulletin*[1] calls attention to a newspaper advertisement describing artichokes as "The new and only nonstarch vegetable garnish for your Thanksgiving turkey. Highly recommended for diabetic and reducing diets." Inquiries have been received from localities widely separated regarding the virtue of the jerusalem artichoke for the diets mentioned. The claim has been advanced that the artichoke, though containing 17 per cent carbohydrate, according to the tables published by the United States Department of Agriculture,[2] contains a sugar, inulin, which is peculiarly suited to the needs of the diabetic patient. This is a claim which has frequently been made and as frequently exploded for honey, on the ground that levulose is better utilized by the diabetic patient than is dextrose, which, of course, is not the fact. The hydrolysis of inulin and its subsequent utilization in the body is no different from that of other sugars, as far as the metabolism of the diabetic patient is concerned. As the *Pittsburgh Medical Bulletin* succinctly remarks, "If the doctor will do the prescribing and the grocer will do the selling, this will be a safer and a better world."—*Jour. A. M. A.*, February 4, 1933.

[1] Pittsburgh M. Bull., December 3, 1932, page 849.

[2] Chatfield, Charlotte, and Adams, Georgian: Proximate Composition of Fresh Vegetables, Circular 146, U. S. Department of Agriculture, January, 1931.

TREATMENT OF ACUTE CORONARY OCCLUSION

EUGENE S. KILGORE, San Francisco (*Journal A. M. A.*, Feb. 4, 1933), states that among the common medical emergencies there are few if any that receive treatment so poor as that of coronary thrombosis—poor in the sense of an average so far below the best that even present knowledge makes possible. But before the average treatment of this condition can be much elevated, the medical profession itself must become considerably better informed. Failure to recognize the condition at all is still the most serious obstacle to good treatment; and after that is failure to visualize the structural changes taking place in the heart and to realize the varied disorders of function which are likely to result and the effect of treatment on them. With the diagnosis made, the treatment that all would agree to be of greatest importance is rest. However mild the initial symptoms, however favorable the *apparent* clinical course, absolute rest in bed should be prolonged sufficiently to permit firm healing in an infarcted area of unknown size. Just how much time is required for enough repair to resist rupture or aneurysmal dilatation is not known. Pain is usually the first symptom demanding treatment, and liberal injections of morphine are commonly administered. This can be indorsed with one reservation. Rizer has called attention to the frequency with which the pain of coronary occlusion can be relieved by oxygen and the need of morphine correspondingly diminished. Stimulants are usually prescribed, and, by force of habit, the one most often selected is digitalis. There are theoretical objections to its use. It usually increases irritability, and one may therefore suspect that it increases the chances of ventricular tachycardia or fibrillation; it depresses conductivity, and this would be decidedly unwelcome in the not infrequent case in which part of the Purkinje system is injured. Stimulation in any form should be avoided unless postively indicated by a dangerously poor circulation, for any heart beat force above that needed to maintain the necessary flow in the brain, lungs and coronaries merely augments the danger of rupture, aneurysm or embolism from intramural clots. The author's principal deviations from current therapeutic procedure are: (1) prolonged absolute rest, regardless of the apparent mildness of the onset and course of the disease; (2) avoidance of digitalis as a rule; (3) early use of oxygen and theobromine, regardless of apparent indications—both in the hope of minimizing tissue necrosis; (4) nutritional adjustment, especially of dextrose and vitamin C, to promote healing, and (5) prophylactic use of quinidine in the hope of preventing the all too frequent and disastrous disburbances of the heart beat mechanism.

THERAPEUTICS OF INTRAVENOUS DRIP

The experiences of HAROLD THOMAS HYMAN, New York, and SAMUEL HIRSCHFELD, Los Angeles (*Journal A. M. A.*, Feb. 4, 1933), which they report in tabulated form, record seven definite indications for the use of the intravenous drip: 1. In hemorrhage or dehydration, the drip will directly restore the fluid volume. 2. In the treatment of shock, the drip apparently acts as a corrective for the underlying abnormality in the distribution of the blood. 3. The drip fulfils a twofold purpose in the management of infections. It functions both as a supportive measure and as the ideal route for the administration of specific therapeutic agents. 4. To the surgeon, the drip possesses value both as a prophylactic against unpleasant postoperative complications and as a therapeutic method once these untoward events have been established. It may act as a supportive to maintain the patient through a prolonged or shocking procedure, and it tends to prevent shock, postoperative thyrotoxicosis and certain of the common postoperative intestinal disturbances, such as nausea and vomiting, postoperative distention of the stomach, and anuria. 5. By means of the drip, the normal level of the blood pressure may be maintained during spinal anesthesia and during exposure of the central nervous system—conditions usually associated with marked and often an alarming fall in blood pressure. 6. The method is of value to the internist in the treatment of toxemias and metabolic abnormalities such as diabetic coma, uremia, cholemia and the intestinal intoxications of infancy and childhood. Solution of dextrose also supplies energy, particularly when the enteral routes of administration are not available. 7. There is also some reason to think that the method may be of value in conditions associated with osmotic and colloidal changes in the central nervous system, such as occur in poliomyelitis and encephalitis.

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MARCH, 1933

EDITORIALS

POSTVACCINATION ENCEPHALOMYELITIS

Although the incident of postvaccination encephalomyelitis is small, the mortality is of such consequence that the subject should be one of great interest. It has been suggested by Armstrong that the above name is preferable to postvaccinal or postvaccinial because the complication follows the vaccination, and that it usually appears at the height of, rather than after the vaccinia.

Not much was heard of the complication before 1922 when reports of it came from Europe in increasing numbers. Between 1922 and 1928 there were ninety-three cases reported in England and one hundred twenty-four in Holland. The ratio in England was 1 to 50,000 vaccinations and in Holland 1 to 5,000. This lower ratio in England is explained by the great number of vaccinations of infants in England.

The reports would indicate that the complication occurs essentially after primary vaccination of subjects between six and eleven years old. Infants below one year are apparently relatively free but one English writer has recently reported twenty-two cases collected from the literature under six months old. The mortality is between 35 and 55 per cent. When recovery results it is usually in two weeks and when it occurs it is complete in most cases.

The nature of the etiology is not known. The possibilities suggested are that the disease is due to an activation of latent encephalitic germs caused by the vaccination, or that the vaccine virus itself is the cause.

The disease develops about the eleventh day after vaccination with an acute onset and rapid course with fever, headache, vomiting, convulsions, strabismus and, commonly, paralysis of the upper motor neurone type. William Boyd gives the pathology as a peculiar rarefaction of the white matter around the vessels, a demyelination.

During the past four years several reports of this complication have appeared in the United States and a suggestion has been made that perhaps some cases reported as tetanus complicating vaccination may correctly have been encephalomyelitis.

No treatment is suggested other than that of some English and Dutch writers who have recommended empirically that vaccinated persons showing severe vaccinia and especially those where nervous disturbances follow, be given serum of recently successfully vaccinated persons.

A study of postvaccination encephalitis from the standpoint of prevention is reported by Dr. Charles Armstrong[1] of the United States Public Health Service. It has been observed that an acute infection occurring with a chronic disorder may favorably influence the chronic one. Armstrong gives instances of this and refers especially to experiments which demonstrate that mice inoculated with diphtheria toxoid are somewhat more resistant to vaccine virus. He suggests that primary vaccinations, especially those given after the first year, be not given until the patient has received a completed immunization against diphtheria or some other disease. It is hoped that a recent mobilization of immunity or defense forces in the body may lead a more efficient anti-vaccine-virus response with mild results and freedom from encephalomyelitis. He suggests that the high percentage of poliomyelitis cases recorded among diphtheria-susceptible children in New York in 1916 may be due in part to an increased resistance to poliomyelitis among diphtheria-immune children.

It is suggested that a first dose of diphtheria toxoid be given at six months of age and a second dose one month later. Vaccination for small pox is then to be given three to four weeks after the final toxoid injection. This procedure is also suggested for older children.

A suitable vaccination technique is defined as one employing a small superficial insertion, never over one-eighth inch in greatest diameter and which employs no routine dressing.

TELESCOPIC SPECTACLES

Recently our attention was directed to several articles in the lay press concerning the "remarkable" results obtained in the use of telescopic spectacles by persons hitherto considered practically blind, and one article goes so far as to state that at least forty per cent of those so afflicted could, by the use of these spectacles, regain useful vision. That these articles have been generally read is evidenced by the fact that many of our oculists already have been consulted in this regard, in most cases only to be told that their dreams are without the possibility of realization.

Many years ago Zeiss first suggested the possibility of telescopic spectacles being useful in cer-

[1] Armstrong, Charles: Public Health Reports, 47:1552 July 22, 1932.

tain cases; probably ten years ago Dr. Harry Gradle, of Chicago, spent no little time in a study of their use and we recall a meeting in Indianapolis in which Dr. Gradle reported the little success he had with telescopic spectacles. In the larger cities some of the wholesale optical companies have provided a set of telescopic trial lenses, to be sent out to their oculist customers for use in individual cases, so it seems that this is not a recent discovery, as the lay press would have us believe.

The true facts of this matter have been given in a bulletin issued by the American Foundation for the Blind and the National Society for the Prevention of Blindness. The opening statement in this bulletin is, "A false hope has been created among many of the blind, their families and their friends throughout the United States by the widespread newspaper publicity given to the announcement in Chicago, December 18th, that telescopic spectacles have been perfected with which vision can be restored to 40 per cent of the present classified blind population." This statement is followed by clear and concise allegations from these authoritative organizations. Not forty, but much less than five per cent can be aided by these spectacles. "The assumption that practically all cases of low vision are capable of being improved by mere enlargement of the images on the retina is false." The report goes on to discuss cases in which the vision is obstructed by opacities, cases in which the optic nerve or retina has lost practically all of its sensitiveness, and many other instances in which optical devices are entirely futile. Oculists know that in many instances in which there is some improvement in vision with the use of these telescopic spectacles, the wearers are unable to use them in their daily activities. Quoting again, "The only change now proposed is the substitution of cylinder lenses for the usual spherical lenses—enlarging the vertical dimensions of images by 30 per cent, while enlarging their horizontal dimensions by 80 per cent. This will improve the patient's ability to judge distance and space correctly, it is claimed, and thus make it easier and safer to walk about while wearing the spectacles. Upon examination, this claim does not appear to be justified for several reasons." In the first place, objects will appear closer than they actually are. Moreover, the use of cylindrical lenses produces distorted or blurred images in which objects appear broader in proportion to height than they actually are. The use of cylindrical lenses in this way is not new and ophthalmologists who have tried it have not found it any improvement.

Of all the hoaxes that are from time to time perpetrated upon the public, those having to do with raising false hopes among the afflicted are the most cruel. Before they were stopped by the law, promoters of false claims were so numerous that they tried to "sell" one another. In more recent times we have far too numerous examples of undue publicity given unfounded claims, resulting in hundreds and thousands of sufferers, grasping at any straw, rushing to seek relief at the hands of the exploiter. Not long ago there appeared in the press a story of the successes obtained by some western physicians in the cure of cancer. Almost simultaneously with the appearance of the article, cancer sufferers in great numbers started westward, seeking the cure. The radio has been helpful to these offenders, for many stations are willing to accept almost any sort of "time" contract. Just now matters concerning vision and the care of the eyes seem to be popular subjects for commercial broadcasts. Within the past few days we have listened to some ridiculous statements, via the radio, concerning some phase of this subject. How far will this sort of thing be permitted to go ere a cease and desist order is issued by the Federal Commission?

WHAT AILS AMERICA?

In any situation where illness obtains, provided the illness is of serious enough character, it is the usual custom to call in specialists in consultation, in order that their experience may serve in aiding the patient to a speedy recovery. Unfortunately, however, it frequently happens that such provisions of knowledge, skill, experience, and ability, are not effective in halting the advance of the disease, and an unhappy outcome becomes inevitable.

Viewing our country today we find it suffering from a very malignant disease called depression, and its tentacles have rapidly infiltrated all phases of our life. In seeking to effect a recovery we have had recourse to many remedies. We have tried stimulants in the form of campaigns of "Buy now —all you can." We have co-operated in the illusionary movement of perceiving prosperity just around the corner. We have tried the radical surgical measures of reducing overhead and pay rolls, cutting off employees, part time employment and a host of others. We have used sedatives in the form of artificial "bull" market rallies and false propaganda. Our emetics in the sugar coated efforts of inflation have been productive only of nausea. We have engaged in an experiment in mesmerism in attempting to cajole the hidden dollar from its "hoarding place." And now we are agitating a shot-gun mixture in our pleas to "Buy American." And throughout this lingering illness we have called upon the experts to consult and advise us as to the cause and to advance the cure for this depleting disease. Perhaps this has been the trouble all along. Too many experts, whose sole aim has been the enhancing of their own power, prestige, or fortune, with utter disregard for the welfare of the country at large, have brought on the moribund state which now exists.

Politicians, in office through political expediency rather than through merit, knowledge, or ability, have through their systems of graft and crookedness depleted the reserve forces of our patient.

Bankers, whose liberality with other people's money has plunged uncounted numbers into distress and despair, have added their share of hemlock to the cup. Tax experts, with their uncanny ability to demand and receive their pound of flesh, have added to the undernourishment and wasting of our patient's vitality. Government officials with their artistic ability to frame new and varied laws and more laws, commissions and more commissions, and bureaus and departments to meddle not only with our own affairs but with those of others, have harassed us to the breaking point. Prohibitionists, who slyly speak one form of action and act another, who vote dry and drink wet, who provide the occasion and frequently the means for evasion and derision of our laws, have taken the stimulating influence of freedom from our patient. Gangsters, who have learned that might is right, that the bottle is mightier than the law, and the racket something more than an implement with which to play tennis, have muscled into the commanding position where they are called upon to aid where the forces of our police powers. Big business, with its strangling of honest competition through mergers, monopolies, and corporations, whose golden rule is the rule of gold, have destroyed faith and left the individual bankrupt and helpless, and has left us cold as banished hope. The press with its sensationalism, bigotry, lobbying and interference with public and individual policies, has made its slogan license instead of freedom. Individuals, self-centered, selfish, hypercritical, living beyond their means, plunging, gambling, stealing, killing, have all contributed to the destruction of the thing we seek to save. The jungle instinct of the cobra could be no more venomous. But why go on? The list is endless. What ails America? Everything ails it. It has been pampered, doctored, and fooled with until resuscitation seems no longer possible.

Well, what's the answer? Where does the hope lie? Perhaps a prophecy is foolish when so many great minds are daily propounding the cure, but it seems to us that at least some help is to be found in the obverse of the expert manipulators who have been in control too long. Threat or promise, the fact remains that the patient is about to make a decided change in doctors. The qualifications of the new advisers will be honesty, ability, and knowledge. They will have to be able to conserve the depleted capital of their patient through adequate guarding of bank deposits, elimination of superfluous taxation as well as its equalization; they will have to get along with fewer assistants in the elimination of deadwood from the government; temperance will have to replace prohibition, and the hoodlum will have to go to work or go to jail. Individual competition must succeed monopoly. Moral and legal fumigation is in order. Faith, hope, and charity must again influence our individual dealings. Humanity must be served. All very nice and very idealistic, but it may all be needed before our sick and weary patient recovers.

Hope is still a virtue when everything seems most hopeless.

APPENDICITIS AND THE DRUG STORE

The mortality of appendicitis is a worrisome part of medical statistics. It does not decrease as it should. The two outstanding difficulties apparently are delay in operation and the administration of purgatives before operation. Both of these may be due to the carelessness of the physician himself who may not take seriously enough the patient with a pain in his abdomen. He may even allow purgatives to be given at his suggestion. The physician knows better but a telephone "visit and advice" at night may be too tempting. The patient is too often his own dopester or he may fear what a physician will tell him and take a chance of waiting and seeing what will happen. One factor which may be overlooked is the drug store and soda fountain. Too often the drug store offers a physic for abdominal distress and too many purgatives are given out over the soda counter. Perhaps the drug-store clerks and the pharmacist, who is often called "doctor" by the clerks, might be admonished that it would be safer to have the advice of a physician before they pass out a bottle of citrate for every bellyache. A sign at the soda counter near the physic bottle might warn the self physicer that a severe stomach ache may be serious and that it would be better to consult his physician before he takes the physic which may make his case more serious should it be appendicitis.

IS A BUSINESS AGENT ADVISABLE?

An editorial in the February issue of the *Bulletin* of the Vanderburgh County Medical Society is of more than passing interest. The editor makes direct appeal for a dictator—a Mussolini, if you please—for the medical profession at large. He cites the work of Landis in the baseball world, and Hays of movie fame, as cases in point, and he suggests that we adopt somewhat similar plans.

Such a suggestion is not without merit, and perhaps is very much to the point. Under present conditions we cannot expect to get anywhere without a more perfect organization. In answer, it may be said that we have many men in our own state Association who are devoting much time and study to problems of medical economics; that we have attained many successes. All of this is very true, but the fact remains that the membership in general has not been aroused to a full sense of its duties. They will not become vitally interested under professional leadership. The mere fact that a member of our society who undertakes a crusade against a certain abuse, for example, no matter how competently he may handle the situation, he

is discredited in the eyes of many of his associates. A layman, undertaking the same thing, is at once accorded a full measure of recognition and support. Too many of our folks stand ready to accuse a fellow practitioner of some ulterior motive, if he undertakes a definite reform of some thing not to our liking, even though his motives may be purely altruistic.

That this thought is more than smoldering in the minds of many of our members is evidenced by the fact that oue of our larger societies now has a special committee looking into the advisability of employing a full time business agent—yes, sir, a *Business Agent!* Just like the union painters, plumbers, etc. When this suggestion was first made to the Council of this society it created a sensation—the other members were astounded at the suggestion that they adopt union labor methods in a medical society. However, after some discussion, the proposal looked less offensive, the idea was endorsed, and a special committee was appointed to investigate it.

This sounds really Soviet-esque, doesn't it? Well, why not? The more we look into, the better we like it. Our state association affords a most excellent example of the advantages to be derived from such a plan. For years we went along with member-secretaries, and these men did their work well; they put lots of time, thought and energy into it. For the most part we were going along in the same old channels, accomplishing about the same things from year to year. Then we tried a part time lay secretary plan, which seemed better and yet left much to be desired. After much travail there was born the present plan, that of a full time executive secretary with a complement of assistants sufficient to do the things we had long wanted to do. From that time, the Indiana State Medical Association began to function as never before, and each year has seen something new accomplished. With our various committees, each spurred to action by the able executive secretary; with a publicity committee recognized all over the country as a pioneer in a most fertile field, and whose work is generally accepted as being the best in the land; with an activity on the part of our presidents not exceeded by those who are honored by the parent organization; with all of these things, we have proved the worth of a change to lay management. We are doing big things, and doing them exceedingly well.

The item of expense in such a proposition is something to think about. To most of our societies, and only the large groups could afford such a plan, it would mean a rather marked increase in dues. However, as someone has said recently, "If our society would try the plan for one year, I am sure there would be no argument about the cost." Big business and little business has changed. Merchants, big and little, are trimming their mercantile sails to meet the changing conditions. Manufacturers and all other producers have had to change plans and methods that had been in vogue for years. Has our profession kept pace with progress, or are we trying to carry on in about the same fashion as did those who have gone before? The traditions of the profession are things beautiful to think about and to read about, but when the whole world has so rapidly changed, and changes still are going on at such a rate that one is hard pressed to keep pace, then it is time for the medical profession to get in step!

STATE MEDICINE

We have recently heard much about "state medicine." What is it? Do any doctors fear that practicing physicians in the capacity of officers duly elected, appointed and paid by the State will, with a certain amount of police power, visit their patients and insist on treating their illnesses, much as the public health officers now insist on their not endangering the health of the community? Yes, we have heard doctors recommend this. Do they fear that certain of the practicing physicians of their communities, on tax provided salaries, will be at the beck and call of their patients to render free medical service? Yes, some doctors have recommended this. Do they fear that some doctors will be so assisted by the State, even a very little, and in any one of many possible ways, that they can enter into disastrous competition with those doctors who must support themselves? Just *what* do they fear? Usually it is the last plan. If so, how does "state medicine" differ from "church" medicine, "industrial" medicine, "military" medicine, "insurance" medicine, "district" medicine (for the indigent of our cities), or, most important of all, "endowed" medicine? All of these have in common one objectionable characteristic, and yet in the heated discussion we have heard it is state medicine alone which is mentioned. Of the others we hear little. Why? One of our friends enlightened us on this point. He said, "We can, since we are tax payers, fight state medicine; these others we can't get at so easily."

What is the objectional characteristic common to all these various "brands" of medicine? Is it not that fundamentally they all, openly or implied, either are at present or probably will be in the future, varieties of "contract" medicine? Under all of these systems certain doctors enjoy, thanks to the State, to an industry, to a church, an endowment, etc., rather exclusive professional privileges in caring either for well-defined groups of patients or for all who care to consult them. In the matter of the compensation of the doctors involved, these forms of medicine may differ, but not much. The military doctor and the district doctor receive flat salaries. The industries and insurance companies now pay according to the service rendered, but they are leaning in the direction of flat salaries. On the other hand, the staffs of some of the endowed medical institutions (as some Uni-

versity hospitals) have for years been salaried men, but already some of these institutions are modifying this plan by the payment of royalties and by concessions concerning private patients on the campus. The tendency promises to be that in all of the above cases, except possibly those of medical teaching centers, the doctors involved will, in the future, receive flat salaries for their services. Such is contract practice. Social workers think that those caring for the community at large also should for a more or less fixed figure care for all the sick of the group assigned to them. This, so far as the general community is concerned, is unthinkable. In the case of the Army and the Navy the medical care of the enlisted men, and often of their families, by those officially appointed and on salaries, is unavoidable. The same is true of the indigent. These patients do not select their doctor nor does he choose his patients. Those great industries operating under employers' liability acts are required by law, and always are prompted by their own interests, to designate the physicians who are to care for patients with conditions for the treatment of which they are financially responsible. Insurance companies may feel the same concerning the care of their insured, but these patients have chosen their occupations and forms of insurance, and therefore must submit to all the conditions inherent in them. Their own (the industries, et al.) interests, however, should prompt them to avoid contract practice.

How far is this form of medical service to go in the case of the general public? The State may demand the right to control, and possibly to provide, the professional care of those with contagious diseases who are menaces to the public. It does so also in the case of the indigent, but with unsatisfactory results. The city, too, often awards to the lowest bidder the medical care of its sick poor. The well-trained doctors do not apply for such work, or they do so only when just starting in practice, and they drop it as soon as they can. The poor often protest, but to assume to organize the medical care of whole communities, including those persons financially able to support themselves, who are related only by the location of the residencies, is a quite different matter.

The average American wants to choose his own doctor; he feels that he is the proper judge of the care he receives; he intends to make his doctor earn his fees; he demands the right, if dissatisfied, to change to another doctor, and even to refuse to pay for services rendered if they did not please him. He wants more than medical service; he wants medical attention. Of the former he is no judge; of the latter he alone can be the judge. When he is ill, he does not like to feel that the only one at his command is probably then busy with other patients, and would doubtless prefer not to treat him, since an additional patient would add nothing to his income. In the case of the municipal or state appointed doctor our patient will suspect, perhaps unjustly, that it was not fitness for his professional duties alone, and perhaps not at all, which got him his appointment. He will suspect also, perhaps unjustly, that the extent of the work assigned to this doctor was probably based on "normal" times, and not on those of epidemic or emergency periods; also, that the total amount of professional service this physician will render will be little more than his salary justifies. The more numerous, therefore, this doctor's patients are the less attention, the patient suspects, will each get. Such professional care does not please the average patient, rich or poor. He wants his own private doctor even though he knows that the contract physician is known to be a better man.

There is, however, one aspect of medical practice which is seldom discussed. As our professional work advances we all should, as do those working in the industries, busy ourselves in the new fields which research has opened up, and we should expect to turn over some of our work which has become standardized and almost "fool proof" to nurses and semi-professional workers. Of course in the case of each patient a physician must supervise all that such workers do for him, but these semi-professional workers should bear a greater burden of developed medicine. The nurse and dietitian today can do much which a few years ago required the courage of a genius. We have in mind the various preventive inoculations and vaccinations, the routine care of the cases of diphtheria, typhoid fever, tuberculosis, gastric ulcer, diabetes mellitus, pernicious anaemia, etc. The intern of today can perform certain operations better than could the eminent surgeon of two generations ago. All such work must have good supervision, but unless we can continuously hand over to the semi-professional groups some of that which has become standardized, our profession cannot advance very rapidly.

Unfortunately there is too much conservatism in medicine. The doctor tends all his life to practice the medicine of his graduation and intern years. This would be fatal to any business. Thanks to our medical society meetings, post-graduate courses, etc., doctors do advance somewhat, but seldom with efficient enthusiasm. In general they merely develop experience and efficiency in the medicine with which they started, merely, and too often, varying their methods by adding bizarre elements to it, thanks to that too influential post-graduate course which agents of various drug and instrument companies carry on in our offices. With advancing medicine they play in a half-hearted manner. This advancing edge of medicine can keep us busy. In those fields the individual physician reigns supreme. "State medicine" at its worst would not compete with him there.

If any social organizations desire to experiment in mass production in medicine, let them create semi-professional institutions where all laboratory, x-ray and many therapeutic facilities are provided

cheap; but let these always be semi-professional. Their application to the individual patients must remain in the hands of the practicing physicians whose patients they are. A few private practitioners thus assisted could care for many more patients than they now do. Since there are so many diagnostic measures and therapies of proven value which can be systematized and popularized for "mass medical service," we should not be surprised if some social service organizations, well guided, would create such institutions, and without medical staffs, other than interns. Meanwhile there is plenty to keep the wide-awake medical man busy on the advancing edge of medicine. There, he can work without fear of state medicine. Such a plan would be hard on the doctors who are specializing in x-ray, laboratory work, etc., but already state laboratories are offering much of such service free. Much better that it be endowed and under control of the profession than of politicians. Also there are today far too many x-ray machines in part time use, and very few who know how to use them. This plan may not be the best. If so, what is a better one? Endowed medicine may have its objections but it is better than political medicine; also, endowed medicine is rapidly gathering momentum. It is a fact that the public is pretty well stirred up, and some radical changes in practice are sure to be made. Something must be done and, as Dr. Wilbur said, "the doctor would better do it than have it done to him."

EDITORIAL NOTES

DEAR DOCTOR:

THE JOURNAL and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital.

We invite and urge you to use this Service.

It is absolutely *free* to you.

The Cooperative Bureau is equipped with catalogues and price lists of manufacturers, and can supply you information by return mail.

Perhaps you want a certain kind of instrument which is not advertised in THE JOURNAL, and do not know where to secure it; or do not know where to obtain some automobile supplies you need. This Service Bureau will give you the information.

Whenever possible, the goods will be advertised in our pages; but if they are not, we urge you to ask THE JOURNAL about them, or write direct to the Cooperative Medical Advertising Bureau, 535 N. Dearborn St., Chicago, Illinois.

We want THE JOURNAL to serve *you*.

IN England and Germany, at the very onset of the socialization of medical practice, the physicians of the respective countries predicted what the end result would be with uncanny accuracy, *but they did nothing*. When the medical history of 1933 is written, shall the doctors of Indiana be credited as being the makers and shapers of affairs of mankind or as mere recorders of passing events?

WE have received information to the effect that a "learn-nursing-by-mail" academy is operating from Fort Wayne, and probably it is a continuation of the school in that city which has changed hands so frequently in past years. If members of the medical profession are asked about any such school, simply tell your inquirers this: If it is a correspondence school, the medical profession is wholly opposed to it, for nursing cannot be taught by mail.

For more than thirty years the Filipinos have been belly-aching for independence. Now that the United States Congress has handed it to them on a silver (or gold) platter, garnished with parsley and "trimmings," the press announces that bells in the Islands will be tolled instead of rung. He who runs may read the lessons of history. Let us point this out to those well-intentioned but misinformed individuals who, by socializing medical service, would degenerate the profession into that of a trade and give to the public an inferior and attenuated service.

SHARKEY and Simpson (J. A. M. A., January 14, 1933) bring to notice a very important matter—the toxicity of sodium fluoride, commonly used in domestic war against certain of the insect pests. It is commonly sold in drug stores, in groceries and other markets and, so far as our personal investigation reveals, does not bear on the label anything to indicate its poisonous nature. Sharkey and Simpson report several cases of poisoning, with one death. The article is worth reading and convinces us that something should be done to advise the using public that they are dealing with a dangerous substance.

"IN the democratic plan of medical organization, the County Medical Society is the basic unit. It is the only door through which admission may be secured to the State and American Medical Association. It is the sole judge of the applicant's membership qualifications. It is the local representative of the State and National organizations. It is the most important unit and therefore has certain very definite and grave responsibilities.

"When the County Society fails, the State and National groups fail. The State society is strong, active and achieving only when its component County units seriously assume and discharge their responsibilities. The parent organizations are dependent upon their basic units. Too often is this fundamental fact overlooked or ignored by the members and officers of County societies."—*Jour. Michigan State Medical Society*, January, 1933.

YEARS ago lye was a dangerous article, causing disability of children by lye strictures of the oesophagus, and much trouble has been encountered in getting proper poison labeling. A few years

ago zinc stearate was being inhaled by infants so frequently that it was necessary to require it to be dispensed in cans with automatic closing tops. Last year we had reports from a Chicago hospital that boric acid had been given to babies to drink, by mistake, killing several of them. Now we have reports of more infants dying in a New York hospital because of using boric acid solution for hypodermoclysis by mistake. Even in the finest piles of rock, and with the best mechanical equipment such as make up the new super-hospitals, there still is the human element with which to deal. Would it not be advisable for hospitals to require that all solutions of boric acid be labeled "poison" and druggists be requested to put poison labels on all boric acid solutions dispensed?

WELL, the old partial cash payment, merely to cover express charges, still works! It is, perhaps, one of the oldest subterfuges to extract a small amount of money from the gullible public. Among the latest sales promotions is that of selling grape juice, a keg of which, placed in your warm basement, soon will become first class wine. Another and similar proposition is that of selling the victim what is purported to be dross from a distilling process. This, with the addition of the proper amount of grain alcohol, undergoes some transformation or other and emerges as "high grade goods" more properly to be termed Bourbon, Rye, Scotch, or what-have-you. (No, we didn't buy; we just listened to the sleek, glib salesman.) Judging from the complaints that have been registered with THE JOURNAL, the salesman was not entirely unsuccessful. The "wine" salesman seems to have worked in Indianapolis, while the purveyor of the material for making "hard likker" operated in Northern Indiana. The sales check carbons sent to us seem perfectly in order, and would indicate that one is dealing with high grade firms, but the fact that remains is that the "goods" have not been delivered. Write your own moral!

The following resolutions of Indiana county medical societies are considered worthy of reproduction in these columns:

BE IT RESOLVED, That we are opposed to state medicine, group hospital, or group medical practice in any form.

Hendricks County Medical Society.

WHEREAS, There is a growing tendency in many communities for certain members of the medical profession to band themselves together into groups, or cliques, for financial gain at the expense of their fellow practitioners, and

WHEREAS, The group practice that results from such activities is prostituting the high ideals and standards of ethical conduct to which every reputable physician subscribes, and

WHEREAS, This movement, if unchecked, will, eventually, result in the establishment of State Medicine that will deprive the physician of his individuality and professional standing in the community and render him a mere hireling by the state, therefore

BE IT RESOLVED, That the Floyd County Medical Society, of Floyd County, Indiana, declare its opposition to all forms of group practice and State Medicine, and

BE IT FURTHER RESOLVED, That a copy of this resolution be sent to the Secretary of the State Medical Association of Indiana and to the secretary of every county society in the state, urging cooperation in opposing this impending evil to both the medical profession and the laity.

Floyd County Medical Society.

WE add to our list of "peppy" secretaries the name of Dr. L. P. Harshman, of the Fort Wayne Medical Society. We have just gone over the list of bulletins sent to the membership during the past year and have but to say that his work is snappy, interestingly done, and, no doubt, is productive of a good attendance at society meetings. There is no question but that a live secretary can and does add much to the success of a county society, and such a man should be retained indefinitely. We are reminded that recently we attended a meeting of a county society, long famous for good attendance and excellent programs, but were more than a little disappointed to learn that it is a policy of the society to change secretaries every two years. This is a serious error, for even in the smaller societies it is a matter of a year or more ere a secretary "learns the ropes" and it matters not whether he is a newcomer to the county or has been there for a long time; two years is all too little for him to become intimately acquainted with his membership. A *good* secretary must know his membership; he must know the fads and foibles of his fellows and he must know just where to turn for an emergency program. If your county secretary is making good, by all means keep him in office.

A LONG time ago someone wrote a book, we believe it was Dr. Cabot, entitled "What Men Live By; Work, Play, Love and Friendship." It was a very readable treatise. We are reminded of this book after having spent a very pleasant evening at the home of a fellow physician, in celebration of his birthday. An excellent dinner, cigars and cigarettes unusually aromatic and satisfying, company much to our liking—all of these provided a good time, even though our bedtime story was delayed until the early hours of the morning. All of this brings up the thought, have doctors forgotten how to play? Perhaps we have reached the age of reminiscence; perhaps present economic conditions have denied us many of the little pleasantries of life in which we were wont to indulge; however, the fact remains that for quite some time we have not enjoyed many get-togethers with fellow practitioners. There is nothing more valuable in bringing about better understanding among a group of physicians than an occasional evening spent in the pursuits usually enjoyed on such occasions. After such an evening, one is

certain to have discovered some previously unobserved traits in the other fellows, no matter how well he knew them before. There is an unquestionable deepening of friendships, and the morrow finds the world with a different aspect. We recommend this treatment for those who seem to have forgotten the Art of Play.

Travelers over the Dunes Relief highway in northern Lake County have witnessed an unusual sight during the past few months—that of peat cutters in action. We of Lake County have been accustomed to seeing these peat bogs burning, occasionally one fire continuing for several months, but until the depression it seems no thought was given to peat as winter fuel. Some idea as to the extent to which this has been carried on may be had from a report on Unemployment Relief Work, just issued by Walter Riley, Chairman for Lake County. He states that some 7,500 cubic yards have thus far been removed from the rather extensive beds. Just across the highway are 2,000 family gardens, a part of the unemployment plan. It was an interesting sight, last fall, to see the peat cutters at work on one side of the road while on the other were family groups harvesting the vegetable crop. Another interesting phase of the heating problem in this part of Indiana is the "mining" of some 30,000 tons of coke. This was salvaged from a veritable mountain of "flue dust" from the Gary steel mills, this dust having been stored over a period of many years with the idea of re-working it, at some future period, for the recovery of the iron contained therein. In East Chicago a large cinder dump was similarly worked, resulting in obtaining several thousand tons of usable coal. More than 20,000 loads of wood were cut and distributed by the various relief committees during the past few months, all in addition to the thousands of tons of coal distributed by the various welfare agencies.

Physicians can render a service especially to the children if some inquiry is made concerning the quality of food that the children are being given during these days of depression. It is a known fact that a child can grow apparently normally even though the calcium content of the body is sadly deficient for a time. The drain on the body's stored supply of calcium offers a serious handicap to the child's growth. With every article of diet requiring an outlay of money by those who live in the city it is to be expected that the milk supply will be sadly curtailed, and that a bulk of food may be given the youngster without regard for its nourishing and vitamin content. Keep up the milk and the vitamins.

The current number of "Antioch Notes" (February 1, 1933) contains a discussion on "Waste" which is the seventh of several issues on "Ethics". The author, after discussing the several sources of waste in production, concluded that 94 per cent of our production capacity is squandered. Discussing the various sources of this production waste we find the following which is of particular interest to the medical profession and which we therefore quote in full: "Industrial dishonesty, graft, bribes, 'greasing the palms' of purchasing agents; 'split fees' in surgery; favoritism; promoting fake securities; exploitation through over-capitalization; manipulation of stock market; corrupting government for profit (there is a bribe giver for every bribe taker). Estimated loss, 10 per cent.

The passing of the late former-President Calvin Coolidge again reminds us that something must be done to relieve the burdens imposed by the American people on their chief executives. Few of them have long survived after their terms have expired and, though they may have entered the White House full of vigor and vitality, and though they are accorded the most competent of medical care during their terms, the fact remains that longevity does not apply to our former presidents. There can be no doubt but that we are too exacting of our presidents; we expect too much of them; there is much that could well be left to some subordinate. In the matter of signatures alone much relief could be accorded by Congressional action, and those who have had occasion to sign innumerable documents at one sitting well know the strain thereto attached. On one occasion we signed more than 2,500 cards, addressed to members of our Association, and when the task was completed, we were completely fatigued. The Annual New Year's reception, when our executive is expected to shake the hands of thousands, could be dispensed with; of course, it is something to talk about to the folks back home, but we are informed that after every such ordeal our president is completely fagged. These are but minor incidents. The American people have come to look to the president for relief from all ills; he is expected, it seems, to be a super-man, capable of assuming all the burdens and all the problems that come before us. Even in "vacation time," when most of us at least try to relax, our president carries on as though he were in Washington, probably working harder because of the fact that he is away from his own office. The press has come to realize these facts and it is hoped that some good may result from the discussions of this very grave problem.

"An adequate community nursing service would include all varieties of skilled competent nurses, their work so coordinated that sick people in every rank of life would get good nursing care." Thus

Edna L. Foley, superintendent of the Visiting Nurse Association, Chicago, introduces her article in the January 1933 issue of *The Modern Hospital.* Nurses are divided into three groups: those working in institutions, those doing private duty nursing, and those in public health work. We, as physicians, are interested in seeing that our patients secure the best nursing care available. Nursing groups have been negligent in explaining to physicians just how long and how much skill is required to give certain treatments, and how impossible it is to attain this skill if it is not founded on knowledge and if the student nurse has not been well taught. Perhaps physicians and surgeons have failed to help nurses set and demand a minimum standard of good nursing. Both nurses and physicians need better organization. They should get together, take each other into their confidence; they should work out some of their problems together, more sympathetically and ethically, and perhaps both groups could profit by taking the public into their confidences. Nurses face the same problems that confront physicians—group care, insurance schemes of various sorts, and all of the other efforts being made at present to convert the private individual into one of a state or federal group. Nursing should be considered a complementary group of a profession whose standard is good service to the public. It is easy for the individual to discuss another person's work, and the medical profession has come in for more than its share of such discussion in the past few years. Some of us are prone to criticize the nursing profession. Perhaps both professions can profit by pulling together.

TECHNOCRACY today is thinking the same thoughts, using the same words, and holding forth the same mirage as of 150 and more years ago. . . . The Rockefeller Foundation invested 2.8 millions in Insull bonds in 1930 and 1931, last quoted at two cents on the dollar; Indiana doctors should not feel so depressed as to their own judgment. . . . The American public spends 365 millions every year on household pets; this is more than one-third of what they pay their doctors. . . . Governments cannot forever continue to balance budgets by constantly increasing taxes; doctors learned this lesson long ago and cut expenses; they had no other recourse. . . . Doctors should be the happiest people on earth; they know (or should know) human physiology and psychology; they should be best equipped to adapt themselves to their environment. . . . Township trustees pay regular retail prices for books, food, coal, and clothing supplied the indigent; doctors give their services to the same individuals at a discount of from forty to one hundred per cent. . . . While the technocrats are talking of a four-hour day and a five-day week, with everybody enjoying a fantastic income, still the indigent and unemployed are cold and hungry in the midst of plenty; doctors, working twelve to eighteen hours a day, on drastically reduced incomes, are "carrying on" as before, and all the sick, whether unemployed or indigent, are given reasonable care. . . . Doctors in active, competitive, private practice will prove the most successful in shaping the future destiny of medical practice. . . . There is danger involved in encouraging or permitting non-medical technicians to assume doctor's duties; cheap service means inferior and deteriorated service. . . . Statistics gathered in 1929 must be scrutinized closely before being applied to 1933 conditions.

AN inquiry from one of our members regarding one Thomas G. Atkinson, who seems to have been the star witness for the defense in the matter of prosecution of a drugless healer who essayed the removal of tonsils via the diathermy route, brings to light some interesting details. The Bureau of Investigation of the American Medical Association has a very interesting story concerning this chap. It seems that he claims to have been licensed by the Royal College of Physicians, London, England, in 1892; that at least part of his preliminary education was gained at the University of London, from which he claims to have received the degree of Bachelor of Science in 1888. The biographical department of the American Medical Association has documentary evidence that these claims are unfounded. Atkinson is credited with having graduated from the American College of Medicine and Surgery, Chicago, in 1905. However, it appears that he entered this school and graduated therefrom all in one year. Later he was listed as a member of the faculty of that school. He operated a "School of Refraction" in Chicago, giving courses by mail and also by residence. He also served as "editor" of the commercial "Red Book of Eye, Ear, Nose and Throat Specialists" for a while. With this unsavory background, Dr. Atkinson is able to appear in an Indiana court as an expert witness, and his testimony had much to do with the failure of prosecution. There are two obvious morals to this: It might be well to check up, in advance, on imported witnesses in such cases; and, the eye, ear, nose and throat specialists might well investigate the various directories which, for a consideration, are willing to advertise those listed therein *ad lib.* When we have the directories of the American Medical Association and of the various special societies, what possible need can there be for a commercial directory of specialists?

Theories concerning the male sex hormone have for many years been subjects of more than usual interest. Very likely the reason for this is to be found in the exaggerated importance that is placed upon the retention of masculine virility by men of middle age and past. It would seem that the logical development would permit a man of this age to re-

gard a reasonable decline in sexual potency as being in the direction of his best interest, but alas, it has been customary to see men frantically grabbing at every possible straw that might enable them to retain the vigor of earlier years. As might be expected, a great many claims have been made by scientists, pseudoscientists and fakers. The recent obnoxious activities of Dr. Brinkley, of Kansas, are ample illustrations of the absurd lengths to which a quack will go. He has made claims concerning goat glands which are so extravagant that no person of intelligence would "bite." It is, perhaps, too much to expect that people will be intelligent about anything which has to do with sex, and particularly when it has to do with the possibility of a man having his former sexual vigor restored. We are reminded of various other "gland specialists" and the extravagant claims which they have made. Foods have been recommended as being capable of restoring vigor. We have been assured that eggs, oysters, "Kentucky oysters," caviar, roe of shad, and other foods are of great value. Likewise we have been told that sun baths, vigorous exercise in the open air, the various manly sports and all sorts of hair-chested activities would greatly enhance one's sexual powers. Various companies have made extracts of testicles of various animals and have claimed that these are exactly what is needed to revive the waning powers. Into this mass of superstition and ignorant claims comes the really scientific research work of Dr. Koch of the University of Chicago, who, with his assistants, is putting the acid test to these claims with interesting results. Most of their work has been done on capons. They have used as a source of their male sex hormone the macerated testicles of the large animals killed in slaughter houses. They find that the male sex hormone seems to be the same in all the animals that they have studied, and that it is undoubtedly closely related chemically to the female sex hormone which has been isolated by other workers. Methods of assay have been worked out and various preparations can now be tested with a degree of accuracy which approaches that of many other biological assays. Now that they have these relatively accurate methods of assay they have been able to concentrate the product to higher and higher degrees, and at each stage to check and determine in which fraction the hormone has gone. They have also been able to find both the male and female sex hormones in the urine of the respective sexes. If as much as five gallons of the urine of a given individual is available, they can determine whether or not that individual is producing an insufficient amount of hormone. A German worker was able to isolate from some 25,000 liters of urine, 15 mgs. of active principle which is apparently the same as that which has been obtained from testicles by Dr. Koch. Most interesting is the observation that this hormone is not absorbed from the alimentary tract but must be injected. This fact itself should dispose of the claims of certain foods and extracts. Koch has shown that the extracts on the market are nothing more than ground testicular substance and that they are almost entirely lacking in any of the hormone for the reason that the fat must be extracted from them before they can be ground fine, and in the fat extraction the hormone is removed. An interesting sideline on Koch's work is that exposure to light weakens rather than strengthens the effect of the hormone. According to his assays it would be necessary to give an individual who is weak in sexual powers the purified extract of a very large amount of testicular substance before it would do any good and that this dose would have to be repeated every day. The expense of this extract at the present time would be absolutely prohibitive for clinical use. The possibilities of this work are very great but at the present stage the main value lies in the fact that we have here exploded the popular belief that declining male powers can be stimulated by the various methods which have been advocated and practiced.

Medicine, as such practice, is about 2,500 years old and during all these various centuries, generation after generation, there has been built up a profession to which we are proud to belong, a profession which has earned and won a high regard from all classes. The pathway not always has been easy; there were many vicissitudes, many trial balloons of thought, many errors both of commission and omission. Yet, despite these, it has plodded onward stride by stride, largely by virtue of a most marvelous code of ethics, of professional conduct. The theme song of this code is the strictly personal relation between the individual patient and the individual physician in whom the patient has placed his confidence. Destroy this, and the professional structure will collapse like a house of cards. The practice of medicine does not lend itself to standardization or machine-ization. It cannot be factory-ized like the Chicago stock yards, where porkers are driven in at one end, and hams, sausages, bristles, leather and glue, come out of the other; or, like the Ford factory, where steel parts are fabricated, nut upon nut and bolt upon bolt, into completed automobiles, each so alike that they cannot be distinguished one from another any better than can new cents from the U. S. mint. The individual reaction to different diseases and the differential in response to therapy by various individuals, all these factors make the relation between patient and physician at once both intimate and personal. Take away the personal relation in these contacts, then, by just so much, you tend to pull down the patient's highest respect and regard for our profession; and, more important, by just so much are we giving our patients a lesser service.

THE PRESIDENT'S PAGE

It has been said that adversity makes love grow stronger. So it appeals to me that forces which apparently are trying to disorganize the medical profession are having the effect of cementing more closely the doctors and making them appreciate more fully the advantages and value of the county, state and national associations. To this end, I wish to comment on the work and accomplishment of some of the committees thus early in the year.

Secretaries' Conference

The Secretaries' Conference was held this year in January, during the session of the legislature, to enable all officers to become personally informed of legislative activities. It was the best conference, with the largest attendance, of any yet held.

Many problems of economic interest to physicians were discussed. Those present felt well repaid for their time, and went home more thoroughly prepared to carry on the work, and more convinced of the value of medical organization.

The outline of work to be accomplished and problems to be solved as presented by Dr. A. M. Mitchell, chairman of the conference, was very complete. The masterly exposition by Dr. Robb, president of the Michigan State Society, of the dangers facing the profession and his suggestions of actions to be taken were enthusiastically received.

Dr. F. S. Crockett reported on the present status of veteran legislation, and pointed out some very encouraging changes that likely will take place.

Dr. E. H. Cary, president of the American Medical Association, was the after dinner speaker. He stressed the necessity of county solidity in medical affairs.

Mr. Thomas A. Hendricks, Executive Secretary, spoke a few moments on work in the legislature, explaining the chiropractic bill and calling attention to the importance of educating uninformed members of the Public Health Committee and unfavorable members of the legislature.

Public Policy and Legislation

The work of the Committee on Public Policy and Legislation in the county units, as well as the state committee, during this session of the legislature has been highly satisfactory. Every physician should thank and congratulate the members of the Public Health Committee of the House who stood for education and high standards when considering the chiropractic bill. We should remember those men who stood for retrogression and low standards. They should not return to public office.

Business Instructional Course

The Committee on Business Instructional Course functioned immediately after its appointment, with the result that the University has put on a course of sixteen lectures, one each week beginning February first. It is gratifying to the state officers to have such cooperation.

Health Insurance

The Committee on Health Insurance has recommended that each county hold one or two meetings on economics this year. Such meetings already have been held in Clinton, Hancock, Delaware, Blackford, Montgomery, Tippecanoe and Owen counties. These are important meetings. The Bureau of Publicity will furnish a speaker who is conversant with suggested plans.

Postgraduate Study

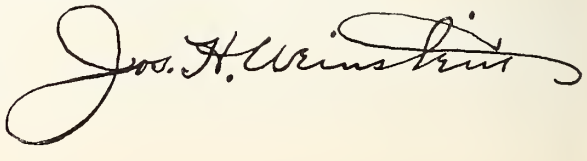
The Committee on Postgraduate Study has the work outlined for the year, and expects to carry out the suggestions made at the Michigan City meeting last year. They hope, by holding the meetings in different sections of the state, to have large attendance and stimulate postgraduate interest and study. They ask your cooperation and attendance. Their efforts are in your behalf.

Scientific Program

Make your reservations for the French Lick session. The Scientific Program Committee has met and outlined a program. The man in general practice is to be especially favored, but the specialist will not be forgotten. French Lick is an ideal place for work and play for three days.

Dues

Medical dues are small as compared to civic club and lodge dues, yet medical dues safeguard your profession. Seven dollars includes THE JOURNAL, protection against malpractice, protection against invasion of cults, cost of the annual meeting, defence of the doctor against unfair industrial and social rules and legislation—many things not possible to enumerate on paper. The local unit cannot function efficiently without funds, nor does one value service received gratis. Now is an important time for close knit militant organization. *There is not a physician who can afford not to keep up his dues, nor who cannot afford one or two dollars a month for this purpose.*



SECRETARIES' COLUMN

COUNTY SECRETARIES' CONFERENCE

The meeting of the County Secretaries, held in Indianapolis January 22nd, was the biggest and best meeting we have ever had; 120 were present for the afternoon meeting, and 105 stayed for dinner.

Dr. J. Milton Robb, president of the Michigan State Medical Association, gave an excellent talk on the "Attitude of the Physician Towards Health Insurance." His paper is printed in full in the January *Bulletin* of the American Medical Association. Be sure to read this article; it will give you a lot of reasons for combating health insurance. It will also show you how to defeat this problem. Health Insurance, either voluntary or compulsory, or both, is the wedge to take the individualistic idea out of the doctor. It puts the doctor in the artisan class.

Dr. E. H. Cary, President, A. M. A., gave a very interesting talk concerning the Majority and Minority reports of the Committee on the Costs of Medical Care. Have you analyzed this subject?

Dr. Weinstein gave an interesting talk on Group Hospitalization and what it means.

Society Plans for Caring for the Indigent

Every secretary should become familiar with the Howard County Plan for indigent sick as put forth by Drs. Craig and Rhorer. See if you can not put some such plan to work in your county. Noble County and Dekalb County are doing nicely in the care of the indigent. The medical society in Vermillion County is putting forth a plan to take care of the indigents, as is also Vigo County.

Veterans Hospitalization

The status of Veterans Hospitalization was very clearly presented by Dr. F. S. Crockett. Since his talk, the Shannon Committee has made some recommendations to Congress. The work done by the committee seems to be bearing fruit.

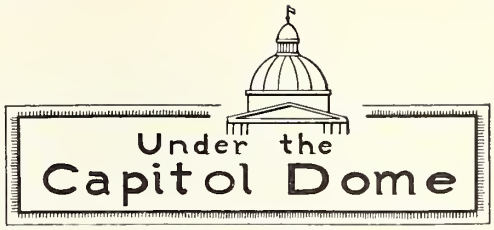
Legislation

Mr. T. A. Hendricks told us about the chiropractoric bill and the beer bill, as it affects the physician. The chiropractic bill has not yet been disposed of, but that part of the beer bill, section 25, I understand, has been changed so that the physician will not have to be a tax collector. Also the sentence that fixed the price for a prescription has been changed.

Resolutions Adopted

The conference adopted resolutions against group hospitalization and the majority report of the Committee on the Costs of Medical Care.

A. M. Mitchell, M. D.



State and local legislative committees are functioning in excellent order, and in the April number of this Journal a report of all bills affecting the medical profession will be made by the state legislative committee.

* * *

A complaint has been made to the Board of Medical Registration and Examination that a drugless physician in Indianapolis has an arrangement with a druggist whereby the "doctor's" patients are supplied necessary medicine on telephonic requests. The patient is instructed to go to this druggist who will give him the medicine needed. The "drugless" physician thereby avoids writing prescriptions. The ways of escaping the punishment of the law are myriad, but all of them are dangerous.

* * *

The Indiana State Board of Medical Registration and Examination has on file the application of a drugless physician for a midwifery examination. The 1927 law specifies that drugless healers may not practice obstetrics, but where there's a will there's a way, and this is one way of getting around the law. Another application for a license to practice drugless therapy discloses that the applicant took his instructional work along with his eighth grade elementary school work and was "actively engaged in the practice of chiropractic on and prior to January 1, 1927," which would have been during his last year in elementary school.

* * *

John A. Brown, secretary of the Board of State Charities, is advocating a program of mental health clinics on a state-wide basis. Cooperation of general hospitals, medical societies, and welfare organizations together with staffs of the state mental hospitals would be necessary to carry out the program which Mr. Brown has in mind. The plan includes prompt care of mental cases in the early stages, in order to prevent the development of chronic and incurable cases; it also includes use of the general hospitals which are not now fully occupied, and in this way providing nursing experience in the care of mental patients.

* * *

The new state law authorizes consolidation of boards and departments. What effect it will have on boards of health, of medical registration and examination, nurses, and other boards, remains to be seen. Governor Paul V. McNutt promises that

nothing will be done to make ineffectual the work of these departments, but, under the consolidation plan, some of these boards may be combined in such a way that the number of employees will be reduced. No definite program has been outlined. There are seven boards in which physicians are more or less interested: the State Board of Health, Board of Dental Examiners, Board of Medical Registration and Examination, Board of Podiatry Examiners, Board of Registration of Nurses, Optometry Board, and Board of Pharmacy.

* * *

The first roars of the March Lion and the last roars of the legislature ring through the State House corridors as you run through your JOURNAL. And it looks as if the ides of March would come and the legislature would go without lowering the standards of medicine in Indiana.

When the legislature convened some fifty days ago, the cultists were most confident of their abiliy to prejudice the General Assembly against the medical profession, and were "cocky" in their claims that they would be able to create a separate board of chiropractic examiners; would be allowed to practice medicine in practically every form; would obtain the right to enter hospitals; would come under the Compensation Act; and, in fact, would flood Indiana with unqualified practitioners. Shortly after the session opened they introduced House Bill No. 148, and when that was unanimously killed by the House Committee on State Medicine and Public Health, they turned to the Senate and finally, only three days before the end of the time limit for the introduction of bills, they induced two senators, Herbert V. Tormohlen and John Bright Webb, to sponsor their measure in the upper House. This bill (S. B. 270) was referred to the Senate Committee on Public Health which recommended indefinite postponement. As the result of a parliamentary trick, the bill has gotten out onto the floor of the Senate, where it is being considered as THE JOURNAL goes to press. It is ready for the second reading. Meanwhile House Bill No. 402 was introduced by Representative Fred Galloway, of Indianapolis, to eliminate the very effective injunction clause from the Medical Practice Act. As no sentiment developed on the floor of the House or in Committee to push this measure, it remains in Committee at the present time.

* * *

A vote of confidence and an expression of thanks is due the House Committee on State Medicine and Public Health from every physician in Indiana, for the decisive action of the Committee in regard to House Bill 148—the chiropractic bill. It is understood that many members of the Committee were rather favorably impressed with the fairness of the chiropractic claims for a separate board when they came to Indianapolis, after being flooded with cult literature and being button-holed by high-pressure lobbyists who were very obvious from the opening day of the session. However, when the members of the Committee heard the side of scientific medicine and began to realize that the cultists had not told them the entire story, they brought out a unanimous report for indefinite postponement of the bill. This was adopted on the floor of the House. The action of this Committee came after a public hearing at which Dr. J. H. Weinstein, of Terre Haute; Dr. W. R. Davidson, Evansville; Dr. F. H. Jett, Terre Haute; Dr. Dan R. Tucker, Indianapolis; Mr. Robert H. Espey, Indianapolis;



BERN B. GRUBB

Dr. F. W. Cregor, Indianapolis; Dr J. M. Barry, Indianapolis; and Mr. Albert Stump, Indianapolis, spoke on behalf of the medical profession. The chiropractors were represented by only one spokesman, Mr. Vetter, head of the Lincoln School of Chiropractic. The entire situation was handled with fairness and with statesmanlike effectiveness, dignity and precision, by the chairman of the Committee on State Medicine and Public Health, Bern B. Grubb, of Lafayette. Other members of the House Committee on State Medicine and Public Health are: W. F. Schenck, M. D., New Corydon; Charles J. Allardt, South Bend; E. M. Dill, Plainfield; John W. Mertz, Corunna; Ray Gilbert, Seymour; Thomas A. Hendricks, Indianapolis; Paul B. Sturm, Dana; Henry C. Asche, Sunman; Herbert H. Evans, Newcastle, and John W. Weaver, Elnora.

Diphtheria Report for January, 1933

We are most happy to report that 1933 starts off with a distinct decrease in the number of diphtheria deaths for the month of January. Furthermore, we are happy to report that the number of cases that are being reported is somewhat less for this season than in the immediately preceding years. This may mean, though we cannot yet be sure, that we have touched the peak and have started down again after the setback that came during the year 1932 and the latter part of 1931.

There were 18 deaths in January of this year as opposed to 25 deaths in January, 1932; 24 deaths in January, 1931; 18 deaths in January, 1930. If it should turn out that we have stopped the increase of diphtheria that came in 1932 and had been predicted two or three years in advance, it will be a most gratifying accomplishment and the profession and the public of Indiana are to be congratulated. Particular attention is called to those counties where there are now a few cases of diphtheria. Those counties should during the next few months continue every possible effort to secure universal immunization and to beware of the let-down which usually comes during the summer months. We are extremely anxious that every possible effort be made to hold the disease down at this particular time inasmuch as the continuation of the epidemic during the next school year will depend upon what is done now and during the coming summer months.

The following counties report deaths for January:

County	*January, 1933*	*County*	*January, 1933*
Allen	1	Shelby	2
Daviess	2	Sullivan	2
Dubois	1	Tippecanoe	1
Howard	1	Vigo	1
Lake	1	Wayne	1
Marion	2	Wells	1
Monroe	1		—
Ripley	1		18

DEATH NOTES

Thomas Hamilton Payne, M. D., of Friendship, died January fifth, aged eighty-nine years. Dr. Payne was a graduate of the Louisville Medical College, Louisville, Kentucky, in 1871.

Alva C. Surber, M. D., of Muncie, died January twenty-seventh, aged sixty-two years. Dr. Surber graduated from the Baltimore Medical College, Baltimore, Maryland, in 1895.

Arthur Lesage, M. D., of Fowler, died February second, aged sixty years. Dr. Lesage graduated from the Northwestern University Medical School, Chicago, in 1898. He was a member of the Benton County Medical Society, and the Indiana State Medical Association.

Frank W. Lose, M. D., of Decatur, died February sixth, aged thirty-six years. Dr. Lose was a member of the Adams County Medical Society, the Indiana State Medical Association and the American Medical Association. He was a graduate of the Northwestern University Medical School, Chicago, in 1922.

Ernest Hollingsworth, M. D., of Washington, died February fourth, aged fifty-seven years. Dr. Hollingsworth was a member of the Daviess-Martin County Medical Society, the Indiana State Medical Association and the American Medical Association. He graduated from the University of Louisville School of Medicine, Kentucky, in 1898.

DeLaskie Smith, M. D., of Lebanon, aged fifty-nine years, died January fifth. Dr. Smith had served as secretary of the Boone County Medical Society and was a member of that society and the Indiana State Medical Association. He graduated from the Medical College of Indiana, Indianapolis, in 1901.

Clinton T. Zaring, M. D., of Greencastle, died January twenty-ninth, aged sixty-nine years. Dr. Zaring was a member of the Putnam County Medical Society, the Indiana State Medical Association and the American Medical Association. He graduated from the Medical College of Indiana, Indianapolis, in 1885.

Thomas B. Cochran, M. D., of Kokomo, died January twenty-ninth, aged sixty-nine years. Dr. Cochran had served as city health officer for Kokomo since 1918 and formerly acted as county coroner. He was a member of the Howard County Medical Society, and the Indiana State Medical Association. He was a graduate of the University of Louisville School of Medicine, Louisville, Kentucky, in 1891.

F. M. Mueller, M. D., of Lawrenceburg, died February 14th, aged fifty-nine years. Dr. Mueller had practiced in Lawrenceburg for thirty-four years. He was a member of the Dearborn-Ohio County Medical Society, the Indiana State Medical Association and the American Medical Association. He graduated from the University of Louisville School of Medicine, Louisville, Kentucky, in 1895.

HOOSIER NOTES

A BUSINESS meeting of the Decatur County Medical Society was held at Greensburg, January 18th.

DR. DONALD COLGLAZIER has taken over the office of the late Dr. James F. Kelley, of Salem.

DR. L. R. MASON, of Muncie, has been elected chief of staff of the Ball Hospital.

DR. J. R. PHILLIPS and Dr. L. M. Robrock are new members of the Michigan City Board of Health.

E. F. JONES, M. D., of Marion, has announced removal of his office from 514 Marion National Bank Building to suite 323-324, The Glass Block.

MEMBERS of the Perry County Medical Society met at Tell City, January 24th, with four members present.

SAMUEL W. KEENE, father of Dr. T. Victor Keene, of Indianapolis, died January 30th. Mr. Keene was eighty-one years of age.

MISS VIRGINIA BLOCK, of Fort Wayne, and Dr. W. F. Englebert, of Fort Wayne, were married January 24th, in Tuscaloosa, Alabama.

MISS MARY MAHONEY, of Anderson, and Dr. Charles Armington, of Anderson, were married January 23d.

DR. WILLIAM V. STANFIELD, of Attica, has been named health officer for Fountain County. The appointment is for a period of four years.

DR. CHARLES P. EMERSON, of Indianapolis, addressed the members of the Howard County Medical Society, at Kokomo, February 3rd.

ANNOUNCEMENT has been made of the appointment of Dr. E. R. Wilson, as superintendent of the Christian Hospital, Indianapolis.

THE regular monthly meeting of the Rush County Medical Society was held February sixth, at Rushville. A banquet preceded the program.

THE Jennings County Medical Society held a meeting in the public library at North Vernon, January 25th. Dr. D. L. McAuliffe, Jr., presented a paper on "Pernicious Anemia."

OFFICERS of the Boone County Medical Society were re-elected for 1933. They are Dr. Robert S. Ball, president; Dr. John D. Coons, vice-president; and Dr. E. A. Rainey, secretary-treasurer.

THE Adams County Medical Society held its regular monthly meeting at Decatur, January 13th. Drs. J. W. Ricketts and A. B. Graham, of Indianapolis, were the principal speakers.

DR. W. H. STEMM, of North Vernon, has been made a member of the executive committee of the Indiana Tuberculosis Association, to succeed the late Dr. Alfred Henry.

MEMBERS of the Posey County Medical Society held a meeting at The Tavern, New Harmony, January 19th. A round-table discussion was enjoyed by the nineteen members present.

THE Boone County Medical Society met at Lebanon, January 17th. A round-table discussion of "Fees" formed the program. Seven members were present.

DR. NORMAN BYERS, of Bedford, read a paper on "Infant Feeding" before the Daviess-Martin County Medical Society at its January 26th meeting, in Washington.

LEE WALLACE DEAN, M. D., of St. Louis, spoke on "The Relationship of Upper Respiratory Infection to Diseases of the Chest" at a meeting of the Muncie Academy of Medicine, January 31st.

MEMBERS of the Elwood Medical Society held their monthly dinner meeting at the Hotel Sidwell Cafeteria, January 24th. Dr. W. W. Woodburn, of Lafayette, was the guest speaker.

OFFICERS elected for the Tipton County Medical Society for 1933, are Dr. J. V. Carter, president, and Dr. R. L. Fullerton, secretary and treasurer. treasurer.

The February 2nd meeting of the Elkhart County Medical Society was addressed by Dr. B. Norman Bengtson, of Maywood, Illinois. His subject was "Alopecia."

Dr. A. E. Newland, of Bedford, has moved his office from the Citizens Bank Building to his residence on Fifteenth street. His new office is modern in equipment and provides ample room.

Dr. and Mrs. Charles A. Inks have moved to Goshen from Ligonier. They formerly resided in Goshen, and Dr. Inks will resume his medical practice there.

Dr. Charles Weirich, of Fort Wayne, has bought the office equipment of the late Dr. F. D. Fanning, and will engage in the general practice of medicine in Butler.

Governor Paul McNutt has appointed Dr. Wilber Dunham, of Kempton, to superintend the State School for Feeble-Minded Youths at Fort Wayne.

Robert Burns Sanderson, M. D., of Crown Point, has been made superintendent of Healthwin Sanitarium, at South Bend, to succeed the late Dr. St. Clair Darden.

The Shelby County Medical Society has established a free medical clinic for the care of indigent persons. It is conducted in the basement rooms of the Major Memorial Hospital, at Shelbyville.

Dr. Ben F. Pence, of Columbia City, led a discussion on "Public Health and Quarantine Regulations" at the meeting of the Whitley County Medical Society, January 10th.

Officers of the Rush County Medical Society for 1933 are Dr. C. C. Atkins, president; Dr. George B. McNabb, vice-president; and Dr. Roy Shanks, secretary-treasurer.

Dr. Franklin S. Crockett, of Lafayette, was the speaker at the annual dinner meeting of the Carroll County Tuberculosis Association, in Delphi, January 17th.

Dr. George D. Beamer has purchased the equipment of the late Dr. John Carney, and has located in Delphi where he will conduct a general medical practice.

Dr. Harry E. Mock, of Chicago, was the guest speaker at the regular monthly meeting of the Allen County Medical Society, Fort Wayne, January 3rd.

The Muncie Academy of Medicine met at the Hotel Roberts, January 10th. Lester Smith, M. D., of Indianapolis, talked on "The Newer Aspects in Radiation Therapy."

Dr. E. M. Amos, of Indianapolis, has been named by the board of county commissioners to the board of managers of the Marion County Tuberculosis Hospital, to succeed the late Dr. Alfred Henry.

"Abnormal Psychology" was the subject of a paper presented by Dr. Kathryn M. Whitten, of Fort Wayne, before the Fort Wayne Woman's Club, January 20th.

Dr. John W. Carmack, of Indianapolis, addressed the members of the Jay County Medical Society, February third. His topic was "Complications of Sinus Infections."

James E. Jobes, M. D., of Indianapolis, has announced the opening of his office for the practice of medicine and surgery at 305 Traction Terminal Building.

Dr. John R. Brayton, of Indianapolis, addressed the Huntington County Medical Society, January third. His subject was, "The Modern Treatment of Syphilis."

The Marshall County Medical Society met at the Marshall County Hospital, February 1st. Dr. Harry Cooper, of South Bend, discussed "Management of Diabetes" before seventeen members.

Members of the Grant County Medical Society met at Marion, January 24th. Twenty-nine members were present to hear Dr. B. W. Rhamy, of Fort Wayne, discuss "Newer Laboratory Aids in Diagnosis."

The January 27th meeting of the Jasper-Newton County Medical Society was held at Remington, with eighteen in attendance. Dr. W. F. Secorf, of Chicago, presented the principal address, his subject being "Diagnostic Points of the Abdomen."

AN informal round-table discussion of "Present Day Problems" constituted the program for the January 26th meeting of the Dearborn-Ohio County Medical Society. The meeting was held at the King Hotel, Lawrenceburg.

THE Wayne-Union County Medical Society met at the Richmond-Leland Hotel, Richmond, January 19th. Dr. Frank Copock, Jr., of Cincinnati, presented an address on "Extra-Uterine Pregnancy." Attendance numbered twenty-four.

DR. LLOYD A. ELLIOTT, of Elkhart, was installed as president of the Elkhart County Medical Society at the January 5th meeting. Other officers are Dr. H. P. Bowser, Goshen, vice-president, and Dr. S. T. Miller, Elkhart, secretary-treasurer.

HISTORY of the Indiana State Board of Health for the past fifty years, including its achievements in the struggle for betterment of public health, is outlined in the bulletin of the Board commemorating its fiftieth anniversary.

THE Delaware-Blackford County Medical Society met at Muncie, at the Hotel Roberts, January 16th. Speakers were Dr. J. H. Weinstein, of Terre Haute; Dr. E. E. Padgett, of Indianapolis; and Mr. Thomas A. Hendricks, Indianapolis.

DR. E. M. SHANKLIN, of Hammond, discussed "Common Eye Diseases" before members of the LaPorte County Medical Society at the Spaulding Hotel, Michigan City, January 19th. Thirty-two attended this meeting.

DR. H. C. WADSWORTH was the speaker at the January 26th meeting of the Washington Rotary Club. Dr. Wadsworth discussed the common cold and the many diseases traceable to the neglected cold.

DR. MURRAY N. HADLEY, of Indianapolis, presented the principal address before members of the Hendricks County Medical Society at the January 20th meeting of the Society. This was a dinner meeting, held at Crawley Hall, Danville.

DR. R. N. FILIATREAU, of Elwood, has been made a member of the board of health of Elwood to succeed the late Dr. T. S. Owen. Dr. Frank Newcomer, who has been president of the board, will serve as secretary.

THE Lawrence County Medical Society met at the Greystone Hotel, Bedford, February 1st. The program included a discussion of the early medical history of Lawrence County and some interesting biographies of the early physicians were presented.

DR. CHARLES M. GIBBS, of Greenfield, first vice-commander of the American Legion, has been advanced to the position of district commander (eleventh district) to fill the vacancy created by the death of C. A. Thompson, of Summitville.

DR. P. J. BIRMINGHAM, of South Bend, recently was made president of the St. Joseph Hospital medical staff in that city. Dr. K. T. Knode was elected vice-president, and Dr. Harold D. Pyle was made secretary-treasurer.

DR. BYRON N. LINGEMAN, of Crawfordsville, has gone to Fort Lauderdale, Florida, where he expects to remain for several months. Dr. R. Denton Smith, of Chicago, will attend Dr. Lingeman's practice during his absence.

THE annual election of officers for the Daviess-Martin County Medical Society resulted as follows: Dr. Maude Arthur, president; Dr. J. H. DeMotte, Odon, vice-president, and Dr. E. B. Smoot, Washington, secretary.

DR. A. E. DALE, of Danville, Illinois, was the principal speaker at the meeting of the Fountain-Warren County Medical Society, held at Veedersburg, February eighth. Dr. Dale's subject was "Diagnosis and Treatment of Goiter."

DR. KARL M. BEIERLEIN, of Fort Wayne, presented a paper on "Dental Care from the Viewpoint of the Obstetrician" before the monthly meeting of the Isaac Knapp Dental Society, in Fort Wayne, February 9th.

TWENTY-FOUR members of the Shelby County Medical Society were present at the regular meeting, February second. Following a dinner, the members discussed the problems of the free clinic which has been established in Shelbyville.

THE Psi Iota Xi sorority has presented an oxygen tent (oxygenaire) to the Cass County Hospital, at Logansport. The Cass County Medical Society met at the Hospital, on January 20th, when the oxygen machine was dedicated, and Dr. Harold Trusler, of Indianapolis, discussed oxygen therapy.

The regular monthly meeting of the Lawrence County Medical Society was held January 4th, at the Bedford Country Club. A moving picture "Skin Cancer" was shown preceding the dinner. Dr. Claude Paynter, of Salem, presented a paper on "Medical Economics."

Members of the Wabash County Medical Society met at the Wabash County Hospital, February 1st, to hear Dr. G. W. Gustafson, of Indianapolis, read a paper on "Obstetrics." At this meeting Drs. Shuler and Ferry, of Kokomo, explained Kokomo's plan of caring for the indigent.

"The Diagnosis and Treatment of Neuroses with Particular Reference to the Freudian Theory" was the subject of an address by Dr. Clarence Neymann, of Northwestern University, at a meeting of the St. Joseph County Medical Society, January 25th.

Dr. L. N. Geisinger, of Auburn, has been re-elected president of the Dekalb County Medical Society for the third consecutive term. Dr. Harold Nugen, of Auburn, was renamed secretary-treasurer for the third time. The meeting for election of officers was held January 12th.

Dr. Ada E. Schweitzer, of the Indiana State Board of Health, was the speaker at a meeting of the Culver League of Women Voters on January 20th, at the Maxinkuckee Inn. Dr. Schweitzer explained the work of her department, the Child Hygiene Division.

Business meeting and election of officers comprised the program for the January 11th meeting of the Putnam County Medical Society at Greencastle. Dr. L. W. Veach, of Bainbridge, was made president, and Dr. Gilbert D. Rhea, Greencastle, secretary-treasurer.

Officers elected December 9th for the Carroll County Medical Society are: president, Dr. Eva Kennedy; vice-president, Dr. W. G. Pippenger; and secretary-treasurer, Dr. E. H. Brubaker, of Flora. Every physician in Carroll County is a member of the society, and every member is paid up for 1933.

Dr. Roy E. Whitehead, of Indianapolis, bears the distinction of being the only flight surgeon in the United States army medical reserve, qualified officially to fly any army aircraft. Dr. Whitehead has been appointed National Aeronautic Association governor for Indiana.

Dr. Frank E. Wiedemann, of Terre Haute, recently made a trip to the Mayan ruins. He spent several weeks vacationing at the ruins of Chichen Itza and Uxmal, the Mecca of the ancient Mayans.

Dr. M. T. MacEachern, of Chicago, director of the hospital division of the American College of Surgeons, addressed members of the Vanderburgh County Medical Society, January 10th. Dr. MacEachern presented five other talks during the day of his stay in Evansville.

Dr. George Iterman of New Castle, was made president of the Henry County Medical Society at a meeting held January 16th, in New Castle. Dr. C. L. Poston, of Lewisville, was elected vice-president, and Dr. George Wiggins, of New Castle, secretary-treasurer.

Dr. G. M. Piersol, of Philadelphia, has been installed as president of the American College of Physicians. He succeeds Dr. F. M. Pottenger, of Monrovia, California. Dr. J. C. Meakins, of McGill University, Montreal, Canada, is president-elect of the College.

The March ninth meeting of the Tippecanoe County Medical Society will be held at Lincoln Lodge, Lafayette A clinic will be held at four o'clock at the Home Hospital. Dr. Robert M. Moore, of Indianapolis, will talk on "The Cardiac Patient as a Surgical Risk."

Members of the Gibson County Medical Society met at the Kidd Hotel, Princeton, February 13th. Dr. E. Vernon Hahn, of Indianapolis, was the principal speaker, his subject being "Better Technique in Office Surgery." Twenty-eight physicians were in attendance. Preliminary arrangements were made for the district meeting, May 18th.

The first 1933 meeting of the Northeastern Indiana Academy of Medicine, held at the Gawthrop Hotel, January 26th, attracted thirty-five attendants. Following a dinner, papers were presented by Dr. C. E. Munk, of Kendallville, whose subject was "Acute Mastoiditis" and by Dr. M. E. Klinger, of Garrett, who spoke on "Hare Lip."

Officers of the Fayette-Franklin County Medical Society were re-elected for 1933 at a dinner meeting of the organization, in Connersville, January 11th. Officers are: Dr. H. C. Metcalf, Conners-

ville, president; Dr. H. N. Smith, Brookville, vice-president; and Dr. R. H. Elliott, Connersville, secretary-treasurer.

THE Reed Drug Company, of Anderson, was host to the Madison County Medical Society for a dinner meeting at The Singing Kettle, southeast of Anderson, January 23d. Dr. J. H. Warvel, of Indianapolis, presented a paper on "Treatment of the Diabetic by the General Practitioner." Attendance numbered forty-five.

A TOTAL of 1,958 persons were immunized recently in Carroll County, as the first step in a county-wide drive to eradicate diphtheria and smallpox. Persons immunized ranged in ages from two months to seventy years. The work was carried out under the direction of the Carroll County Medical Society.

DR. HARMON L. STANTON, president of the city board of health of Evansville, has been elected president of the Vanderburgh County Medical Society. Dr. C. C. Wilson was re-elected vice-president of the society, and Dr. Keith T. Meyer was re-elected secretary-treasurer. Dr. L. E. Fritsch was named delegate to the French Lick session.

THE Henry County Medical Society met at the Henry County Hospital, Newcastle, February ninth. Dr. W. J. Dieter discussed the life and habits of the people of Vienna, and Dr. George Wiggins discussed a case of eclampsia. Seventeen members were present.

THE Nobel prize in medicine for 1932 was awarded to Sir Charles Scott Sherrington, of Oxford, and to Professor Edgar Douglas Adrian of Cambridge. The work of the former had to do with nerve activity, and of the latter with investigations on nerve conduction mechanism by amplifying and measuring the currents in nerve fibers through the methods of modern radio.

THE Twenty-ninth Annual Congress on Medical Education and Licensure, held under the auspices of the Council on Medical Education and Hospitals of the American Medical Association, was held at the Palmer House, Chicago, February 13th and 14th. Main topics of discussion were recognition of specialists, nursing, medical economics, and licensure problems.

"HEAD Injuries" was the subject presented by Dr. Jewett V. Reed, of Indianapolis, before members of the Porter County Medical Society at Valparaiso, January 31st. At this meeting a plan was outlined to provide diphtheria immunization for all children attending the Valparaiso schools at nominal cost, through cooperation of the school board and city physicians.

IN the month of December, the Federal Food and Drug Administration caused the seizures of 100 consignments of foods and drugs found to violate the national pure food and drug law. Among these were shipments of substandard anesthetic ether and proprietary preparations labeled with false and fraudulent curative claims.

DR. ROBERT POLLOM, of Darlington, was elected president of the Montgomery County Medical Society at a meeting held in Crawfordsville, January 5th. Dr. A. L. Loop, of Crawfordsville, was made vice-president, and Dr. George Collett, secretary-treasurer. Mr. Albert Stump, of Indianapolis, attorney for the Indiana State Medical Association, addressed the meeting.

DR. S. P. HOFFMAN, of Fort Wayne, made the first talk on the morning program of the regional meeting of public health workers in Kendallville, January 14th. His subject was "The Doctor and the Public Health Nurse." Dr. William F. King, secretary of the Indiana State Board of Health, addressed the meeting, and several laymen completed the program.

DR. A. L. MARSHALL, of Indianapolis, has been made president of the board of directors of the Marion County Tuberculosis Hospital at Sunnyside, and Dr. William McQueen, assistant superintendent of the Hospital, was made superintendent at a meeting of the board, January 16th. Dr. Marshall succeeds the late Dr. Alfred Henry. Dr. McQueen takes the place of Dr. H. V. Scarborough, who resigned.

THE February 9th meeting of the Hancock County Medical Society was held at the home of Dr. and Mrs. Charles Titus, of Wilkinson. Fifty-five guests were served a turkey dinner at a banquet table decorated with models showing the progress of transportation. An instrumental trio supplied music during the banquet. Drs. John A. McDonald and Larue D. Carter, of Indianapolis, presented scientific papers.

At a meeting of the Clinton County Medical Society in Frankfort, January 5th, Drs. R. A. Craig and H. M. Rhorer explained the plan for medical care of the indigent in Howard County. Physicians from Tippecanoe, Carroll, Howard, Marion and Clinton counties attended the meeting. Other speakers included Dr. J. H. Weinstein, of Terre Haute; Dr. E. E. Padgett, of Indianapolis; Dr. C. M. Kennedy, of Camden, and others. Attendance numbered thirty-seven.

Dr. Alfred S. Burdick, president of the Abbott Laboratories of North Chicago, Illinois, died February 11th, of pneumonia, at the age of sixty-six. In 1921 Dr. Burdick was made president of the Abbott Laboratories. Under his presidency the Swan-Myers Company, of Indianapolis, was consolidated with the Abbott Laboratories, and many other improvements are tributes to the genius and wisdom of Dr. Burdick.

The National Committee for Mental Hygiene, 450 Seventh Avenue, New York City, has issued a pamphlet entitled "Morale: The Mental Hygiene of Unemployment," by George K. Pratt, M. D. The pamphlet is divided into four parts: I. How We Act in the Face of Adversity; II. The Conditions Necessary for Good Mental Health; III. What the Depression Is Doing to Family Life; IV. Mental Hygiene Suggestions. Single copies are twenty-five cents; discounts are given for quantity orders.

Dr. E. B. Mumford, of Indianapolis, was made vice-president of the Clinical Orthopedic Society at the recent meeting held in Chicago. Dr. Mumford also was elected treasurer of the newly established American Academy of Orthopedic Surgeons. Dr. Willis Campbell is president of the new organization which is composed of active members whose practice is limited to orthopedic surgery, and to associate members whose surgical interests are largely that of bone and joint work but not exclusively limited.

On January 8th, E. R. Squibb and Sons Company presented the first of a series of half-hour radio programs. This half-hour of entertainment is broadcast over the National Broadcasting Company chain, at 4:30 p.m., New York time, every Sunday. It features Frank Black and his orchestra, the Revelers, and presents dramatic episodes from the history of medicine. The announcement emphasizes that only through a sufficient number of properly trained physicians can a community expect to meet its responsibility for the care and prevention of illness and the protection of health.

Members of the Hancock County Medical Society met at Greenfield, January 12th, at the Bowman Hotel. Discussions included the Report of the Committee on the Costs of Medical Care, medical legislation, economics, and group clinics. Thirty-five physicians attended the meeting, among them being Dr. J. H. Weinstein, president of the Indiana State Medical Association; Dr. E. E. Padgett, president-elect of the Association; executive secretary Thomas A. Hendricks; Senator I. N. Trent; Dr. W. F. King, secretary of the Indiana State Board of Health, and councilor for the Sixth District, Dr. Samuel Kennedy.

The February seventh meeting of the Indianapolis Medical Society, held at the Athenaeum, had for its program a symposium on rectal disease. Papers were presented by Dr. George W. Combs and Dr. H. H. Wheeler; discussants were Dr. A. B. Graham and Dr. J. W. Ricketts. The younger men of the Society were speakers on the program for the February fourteenth meeting. The entire program was given to young men who had been in practice five years or less. Dr. I. J. Kwitney discussed "Tuberculous Meningitis"; Dr. A. E. Soudah had for his subject "Intestinal Tuberculosis"; and Dr. Paul Cullen talked on "Anesthesia in Pulmonary Tuberculosis." Discussants of these papers were Drs. Murray DeArmond, Paul Iske and B. J. Matthews.

Newly-elected officers of the Woman's Auxiliary to the Indianapolis Medical Society are: President, Mrs. William S. Tomlin; vice-presidents, Mrs. William H. Link, Mrs. Henry S. Leonard, Mrs. H. F. Beckman, Mrs. J. K. Leasure; recording secretary, Mrs. Russell Hippensteel; corresponding secretary, Mrs. G. W. Seaton; treasurer, Mrs. Frank M. Gastineau; publicity, Mrs. H. F. Nolting. Mrs. Tomlin has appointed the following chairmen of standing committees: Program, Mrs. Lehman Dunning; Social, Mrs. D. O. Kearby; Hygeia, Mrs. A. S. Ayres; Legislation, Mrs. E. E. Padgett; Memorial Planting, Mrs. Davis Ross; Historian, Mrs. Edmund D. Clark; Parliamentarian, Mrs. Charles E. Cottingham; Bulletin, Mrs. James C. Carter.

The Kelley-Koett Manufacturing Company has announced the opening of offices in the Architects and Builders Building, in Indianapolis. Sales, service and supply departments have been installed. The office is a direct branch of the factory at Covington, Kentucky, and is under the management of Mr. Fred H. Fritts. The announcement appears on advertising page iii in this issue.

INDIANA UNIVERSITY NEWS NOTES

The second semester of the present school year at Indiana University opened with registration Monday, January 30th. Enrollment was Tuesday and regular classroom and laboratory work got under way Wednesday morning, February first. Enrollment for the second semester practically is the same as that of the first semester, which was 4,035.

DR. WILLIAM M. DUGAN, graduate of the Indiana University School of Medicine, has been reappointed resident physician of the Methodist Hospital, Indianapolis. Before taking up his duties last year as resident physician of the Indianapolis Hospital, Dr. Dugan was assistant to Dr. William E. King, former resident physician. Dr. Dugan has done postgraduate work in internal medicine at the University of Pennsylvania.

DR. THURMAN B. RICE, professor of bacteriology and public health in the Indiana University School of Medicine, is offering a course in the study of birds for the second semester of the Indiana University Extension Center at Indianapolis. The course in birds will be supplemented by Saturday morning excursions in the woods. The course is intended for people who desire it as a cultural asset or for teaching purposes.

EXPANDED usefulness of the James Whitcomb Riley Hospital for Children at Indianapolis, with a greater number of patients treated at lower daily per capita costs, has been reported by the Riley Memorial Association. Despite restricted operating funds, Dr. Edwin T. Thompson, administrator of the Indiana University hospitals, which include the Riley Hospital, reported 497 more patients admitted during the year 1932 than in the previous year. The per capita daily cost of care was reduced in the last quarter to $2.95, a figure lower by 15 cents than any since the hospital was opened.

THE Indiana University School of Medicine has announced a new course in medical economics and medical ethics to be given to the senior class this semester. The purposes and content of this course have been approved by the Indiana State Medical Association, which has appointed a committee, composed of Dr. George J. Geisler, South Bend; Dr. Cyrus Clark, Indianapolis; and Dr. G. D. Scott, Sullivan, to co-operate with the faculty of the medical school in giving the course. Members of the association are invited to attend the lectures which began Wednesday, February 1, and will continue every Wednesday afternoon at 1:00 o'clock.

The recent service report for 1932, by Dr. E. T. Thompson, administrator of the Indiana University medical school and hospitals, showed that the three Indiana University state hospitals had 13,001 patients, as compared with 12,187 the year before. Of this number 8,608 were bed patients in the hospitals and 4,393 were out-patients. The Riley hospital led in numbers with 5,169 patients. The Long hospital was next with 4,159, and the Coleman hospital had 3,673. Nine hundred and thirty-one babies were born at the Coleman hospital during the year.

Following an examination under auspices of the American Medical Association, the three Indiana University hospitals at Indianapolis have been continued on the Association's approved list for interneships and residencies. The three hospitals whose high rating has been extended are the Robert W. Long hospital, the Coleman Hospital for Women, and the James Whitcomb Riley hospital for children.

High standards of instruction and hospital management are required by the American Medical Association for hospital interneships and resident physicians. In this connection, it was pointed out that practically all of the Indiana University medical school graduates accept hospital interneships before going into active practice. Appointment to these positions each year, in some cases by competitive examination, give I. U. graduates an opportunity for advanced training in the leading hospitals of the country. For a number of years many more students have sought admission to the medical school than could be accommodated with laboratory facilities and this selectivity of student applicants has brought about unusually high standards. Last fall more than 350 applicants for medical training could not be accommodated because of shortage of laboratory space.

In the opening lecture of the course arranged for the seniors of the Indiana University Medical School by the Indiana State Medical Association, Professor Daniel S. Robinson, head of the philosophy department of the University, discussed the general principles of theoretical and applied ethics. Using the famous Bollinger baby case as an illustration, he showed how the rightness or the wrongness of an act such as the refusal to operate to save the life of a physically defective new-born babe has to be determined by the surgeon in the light of what he regards as the total probable effects of his act upon everyone concerned, as well as by the relation of his act to some general law of morality such as "value life." He discussed the three basic questions of applied ethics: What ought I to do? or the doctrine of specific duties; What ought I to have? of the doctrine of human rights; and What ought I to be? or the doctrine of virtues. He showed how Medical Ethics is related to these fundamental divisions of applied ethics, and how the ethical code of the American Medical Association makes use of these questions in formulating its statements of the rights and duties of the physician.

WOMAN'S AUXILIARY, INDIANA STATE MEDICAL ASSOCIATION

I have accepted the chairmanship of Press and Publicity under Mrs. O. O. Alexander. I hope to develop our Auxiliary Column so that our members will look forward to reading it, and become conversant with our ideas and ideals. Besides our own news items, I wish to draw attention to National Auxiliary affairs and to problems of the medical profession that affect the home life of physicians. My copy must be in THE JOURNAL office on the tenth of the month; therefore, I beg for county auxiliary reports by the first of the month.

Mrs. Walter Jackson Freeman, of Philadelphia, who was our honored guest at the Michigan City convention, died one month later. Mrs. Freeman was pre-eminently fitted for the stupendous task of being our national president—by birth, the daughter of the renowned Dr. William Keen; by marriage, a physician-husband; by motherhood, two physician-sons; by interest, in everything connected with medicine. To quote Mrs. Freeman, "The day that saw the birth of preventive medicine made inevitable the birth of the Auxiliary." "I regard public relations as the most important and most promising field of auxiliary work." "The more organizations the better—the greater the contacts! "The Woman's Auxiliary, trained and guided by the medical profession, is the answer to the physicians' anxious query, 'How may we reach the public ear?'" In the November *Bulletin* of the A. M. A., a beautiful tribute is paid Mrs. Freeman by her successor, Mrs. James F. Percy, of Los Angeles, California. Mrs. Percy closes "Our efforts will be strengthened with a fine unity of purpose to which each, we ask, shall pledge herself in memory of the one who is gone."

The Indiana Auxiliary pledges itself to carry on in memory of Mrs. Freeman, and to be a stronghold for Mrs. Percy.

Dr. Morris Fishbein appreciates the value of public relations, or club contacts, as evidenced by these words from "Dr. Pepy's Diary" under date of January 11, 1933: "So now in Worcester, Massachusetts, to speak to ye ladies of ye women's club and a fine thing to see here ye wife of a physician as president and another as ye head of ye program committee and, this, indeed, ye finest service which a woman's auxiliary to medicine may render."

Mrs. Tomlin is arranging an early meeting when Mrs. I. N. Trent, of Muncie, president-elect of the State Auxiliary, Mrs. George Miller, Logansport; Mrs. George E. Denny, Madison, and Mrs. William F. Shenk, New Corydon, will be honor guests.

MRS. FRANK W. CREGOR.

SOCIETIES AND INSTITUTIONS

INDIANA STATE MEDICAL ASSOCIATION BUREAU OF PUBLICITY

January 10, 1933

Meeting called to order at 4:00 p. m.

Present: William N. Wishard, M. D., chairman; J. H. Stygall, M. D.; E. D. Clark, M. D., and T. A. Hendricks, executive secretary.

Release for publication in Saturday morning papers, January 21, "Disease Prevention Pamphlet," read and approved.

Radio release, Saturday, January 7, "Sinus Trouble."

Reports on medical meetings:

December 14, 1932. Ripley County Medical Society, Osgood, Ind. "The Legal Aspect of Poor Relief."

December 16, 1932. Knox County Medical Society, Vincennes, Ind. "The Medical Profession in the Changing Social Order."

The Bureau approved a letter to be sent to the officers and councilors of the Indiana State Medical Association and the county society secretaries along with a supply of the pamphlets regarding the prevention of contagious diseases.

INDIANA STATE BOARD OF HEALTH DIVISION OF COMMUNICABLE DISEASES

Monthly Report, January, 1933

Current prevalence of the more important communicable diseases as indicated by the reports of health officers, physicians and hospitals of the state, show a favorable decline as compared with the previous month. There were 4,207 cases of disease reported; 7,412 cases the previous month and 2,173 cases the corresponding month the preceding year. The high prevalency is due to the epidemic of influenza. Every county in the state reported either positive or negative. Reports were sent in from cities of 5,000 population and over except Bloomington, Vincennes, Columbus and Bicknell. Nine hundred and six negative cards were received.

A summary of diseases from the urban and rural population is given below:

Diseases	*Total Reported*	*Urban*	*Rural*
Tuberculosis	162	81	81
Chickenpox	386	279	107
Measles	53	41	12
Scarlet Fever	511	199	312
Smallpox	12	4	8
Typhoid Fever	10	5	5
Whooping Cough	117	105	12
Diphtheria	226	112	114
Influenza	2,431	690	1,741
Pneumonia	126	18	108
Mumps	145	139	6
Poliomyelitis	1	0	0
Meningococcus Meningitis	18	16	2
Trachoma	1	1	0
Undulant Fever	6	3	3
Tularemia	1	0	1
Pellagra	1	0	1
Grand total	4,207	1,693	2,513

INFLUENZA. The incidence of the prevalence of influenza shows a decline of 47 per cent as compared with the previous month, when 5,118 cases were reported. The disease has been widespread over the state, especially in the rural area, and is comparable to the epidemic of 1928. In January last year, 171 cases were reported.

SCARLET FEVER. There is a low prevalence of scarlet fever as compared with the last several years. There were 575 cases

the previous year, but in January of 1931, 1,559 cases were reported. The estimated expectancy was 855 cases. The estimated expectancy is based on the experience of the last seven years. No doubt the low level of the last two years is due to the mild winter weather. Scarlet fever is a cold weather disease.

DIPHTHERIA. A favorable decline is noted in diphtheria—388 cases were reported in January of last year. The current number (226 cases) is only a few cases above the normal average for the last five years, which is 218 cases. This indicates that the disease is gradually declining.

SMALLPOX. The incidence of the prevalence of smallpox (12 cases) the current month is the least number of cases reported in January in the history of the Division; twenty-nine cases the previous month and eighty-four cases the corresponding month the preceding year. The estimated expectancy for January over a seven year period is 491 cases. There is a low prevalence of the disease throughout the states.

TYPHOID FEVER. The prevalent incidence of typhoid fever (10 cases) shows the season's low level. Twenty-three cases were reported the previous month and twenty cases the corresponding month the preceding year. The estimated expectancy was fourteen cases. The estimated expectancy is based on the experience of the last seven years.

MENINCOCOCCUS MENINGITIS. There was a slight increase of meningococcus meningitis. Fourteen cases the previous month and sixty-one cases the corresponding month the preceding year. Ten cases were reported from Marion County. The remaining cases were scattered over eight counties.

H. W. MCKANE, M. D., *Director.*

CLINTON COUNTY MEDICAL SOCIETY

The Clinton County Medical Society met in regular session at the Coulter Hotel, February 2nd, Frankfort, with Dr. John S. Ketcham presiding.

Roll call showed eleven members present, and Drs. A. M. Mitchell, of Terre Haute, Frank S. Crockett and W. W. Washburn, of Lafayette, as guests of the Society.

The second meeting to discuss medical economics was held with the following program:

Trend Toward State Medicine....Dr. W. W. Washburn
Report on the Costs of Medical Care..A. M. Mitchell
Veterans Hospitalization.....Dr. F. S. Crockett

All of these papers were well-prepared and well-received.

The members of the Clinton County Medical Society may well be proud of the talent they have had with them in the past two meetings to discuss the subject of medical economics. If other county medical societies over the State would devote as much time, under such capable leadership, we could accomplish something for the cause in the near future. This Society unhesitatingly recommends any and all of the papers or speakers for any society that wants some addresses along this line. The Clinton County Medical Society feels that it is to be congratulated upon the good talent that it has had on its programs this year.

IVAN E. CARLYLE, M. D., Secretary.

LAKE COUNTY MEDICAL SOCIETY

The Lake County Medical Society met in regular session at St. Margaret's Hospital, Hammond, Thursday, February 9, 1933, President Jones presiding. This was a dinner session, dinner being served by the good Sisters.

The minutes of the January session were read and approved.

The Chair announced the following committee appointments for the current year:

Medical Economics: Pugh, Lauer, Schaible, Oberlin, White and Craig.

Educational Committee: Forster, Oberlin and Baitinger.

Shanklin reported as to the Legislative Committee.

Dr. Pugh, Secretary of the Surgical Section of the State Association, suggested that we should have representation on the state program, at French Lick, and urged those wishing to appear on same to get their applications in at an early date.

Dr. Rauschenbach introduced the guest speaker of the evening, Dr. Geo. H. Gehrmann, of Wilmington, Delaware, who spoke on "The Industrial Physician; His Duties and His Problems." His address had to do with the medical hazards of various occupations, chiefly those within the various plants of this great organization.

His subject brought forth a great deal of interesting discussion and proved of much value. He detailed at some length the method used in employment examinations, the assignment of various applicants to work for which they were best physically adapted. He was of the opinion that the control of industrial disease was by prevention only.

His detailed discussion of tetra-ethyl lead was a very interesting part of the program.

Dr. Jones expressed the thanks of the society to Dr. Gehrmann for his most interesting talk and to Sister M. Vincentianna for a very enjoyable dinner.

Adjourned.

E. S. JONES, President.
E. M. SHANKLIN, Secretary.

ELKHART COUNTY MEDICAL SOCIETY

February 2, 1933.

The Elkhart County Medical Society met in the Empire Room, Hotel Elkhart, at 6:30 p. m. After the dinner, the meeting was called to order by the president, Dr. L. A. Elliott.

A case of alopecia was presented by Dr. S. T. Miller, and discussed by the speakers of the evening, Dr. B. Norman Bengtson, of Maywood, Illinois, who addressed the society on the subject "Pituitary Therapy in Alopecia." Discussions were presented by Drs. F. A. Lampman, A. C. Yoder, A. W. Hull, H. W. Eby, A. A. Norris, and Dr. Bengtson.

It was moved and seconded that the following resolution be telegraphed by the legislative committee to our legislators at Indianapolis: "Resolved, that the Elkhart County Medical Association, now assembled in the city of Elkhart, is opposed to the enaction of legislation imposing a sales tax by the legislators now in session at Indianapolis." Carried.

It was moved and seconded that the president appoint a program committee and a committee on arrangements for the annual meeting to be held in April. Carried. The president appointed the following: program, Drs. A. W. Hull, A. W. Kistner, R. H. Young; arrangements, Drs. J. C. Fleming, H. W. Eby, F. A. Lampman.

The minutes of the previous meeting were read and approved.

A letter from the State Board of Medical Registration and Examination was read, in which inquiries were made regarding a Mr. Boyer, said to be practicing medicine without a license in the county.

Letter from Mr. Thomas A. Hendricks was read by Dr. A. C. Yoder, regarding sales tax legislation.

A report on the meeting of the county secretaries of the state, held in Indianapolis on January twenty-second, was given by the secretary.

Thirty-six doctors were present.

Adjourned.

S. T. MILLER, M. D., Secretary.

BOOK REVIEWS

Books are acknowledged in the first possible issue after they are received. Reviews will be given to those books meriting review in subsequent issues.

Books received since January 1, 1933:

GENERAL MEDICINE. Practical Medicine Series, 1932. Edited by George H. Weaver, M. D., Lawrason Brown, M. D., George R. Minot, M. D., William B. Castle, M. D., William D. Stroud,

M. D., and Ralph C. Brown, M. D. 837 pages. Cloth. Price $2.50. The Year Book Publishers, Chicago, 1932.

OUTLINE OF PREVENTIVE MEDICINE. For Medical Practitioners and Students. Prepared under the auspices of the Committee on Public Health Relations, New York Academy of Medicine. Twenty-four contributors. Second edition, revised and enlarged. 462 pages. Flexible binding. Price $5.00. Paul B. Hoeber, Inc., New York, 1932.

YOUR TEETH AND THEIR CARE. By Carl W. Adams, D. D. S. 141 pages. Illustrated. Cloth. Price $1.25. The C. V. Mosby Company, St. Louis, 1932.

SURGICAL CLINICS OF NORTH AMERICA. Philadelphia Number, December, 1932. Issued serially, one number every other month. Index number. 280 pages, with 110 illustrations. Per clinic year (February, 1932 to December, 1932) paper, $12.00; cloth, $16.00. W. B. Saunders Company, Philadelphia and London, 1932.

OFFICE SURGERY. By Fenwick Beekman, M. D., visiting surgeon, Bellevue Hospital; clinical professor of surgery, New York University and Bellevue Medical College. 402 pages, with 94 illustrations. Flexible binding. Everyday Practice Series, edited by Harlow Brooks, M. D. J. B. Lippincott Company, Philadelphia and London, 1932.

HISTORY OF DERMATOLOGY. By William Allen Pusey, A. M., M. D., LL. D., professor of dermatology emeritus, University of Illinois. 223 pages, illustrated. Cloth. Price $3.00. Charles C. Thomas, publisher, Springfield, Illinois, 1933.

SURGERY. With Special Reference to Podiatry. By Edward Adams, M. D. 480 pages. Cloth. International Journal of Surgery Company, New York, 1932.

THE GOLD-HEADED CANE. By William Macmichael, M. D. Edited with explanatory and illustrative notes and an essay on William Macmichael, M. D., by Herbert Spencer Robinson. Containing the original illustrations of the 1828 edition and hitherto unpublished portraits of the Macmichael family. 223 pages, with a few illustrations. Cloth. Price $3.50. Froben Press, Inc., New York, 1932.

CORRECTION OF DEFECTIVE SPEECH. By Edwin B. Twitmyer, Ph. D., and Yale Samuel Nathanson, Ph. D. 413 pages. Cloth. Price $3.50. P. Blakiston's Son and Company, Philadelphia, 1932.

PROCEDURES IN TUBERCULOSIS CONTROL, for the Dispensary, Home and Sanatorium. By Benjamin Goldberg, M. D., F. A. C. P., F. A. P. H. A., associate professor of medicine, University of Illinois. A chapter on sanatorium planning by Thomas B. Kidner, and introduction by David J. Davis, M. D., Ph. D. 373 pages, with 54 illustrations. Cloth. Price $4.00. F. A. Davis Company, Philadelphia, 1933.

FOOD IN HEALTH AND DISEASE. Preparation, Physiological Action and Therapeutic Value. By Katherine Mitchell Thoma, B. A., director of Dietetics, Michael Reese Hospital, Chicago. 370 pages. Cloth. Price $2.75. F. A. Davis Company, Philadelphia, 1933.

BOOK REVIEWS

CLINICAL ENDOCRINOLOGY OF THE FEMALE. By Charles Mazer, M. D., F. A. C. S., and Leopold Goldstein, M. D., 518 pages, with 117 illustrations. Cloth. Price $6.00. W. B. Saunders Company, Philadelphia and London, 1932.

This book represents intensive research and contains the newer knowledge of the endocrine system, both physiologically and therapeutically. The ovary, pituitary gland, thyroid, adrenals, and parathyroids, are considered in separate chapters, as is the interrelationship of the endocrine glands. Menstrual disorders are dealt with in great detail and two chapters are devoted to their treatment. Some of the newer ideas of functional sterility are given, but it still remains one of our greatest problems. Other chapters include the hormone tests for pregnancy, ovarian transplantation as a therapeutic measure, and endocrine obesity. The book is very well illustrated and contains an extensive bibliography and a very good index.

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SURGICAL CLINICS OF NORTH AMERICA. August, 1932. (Issued serially, one number every other month.) Volume 12, number 4. Mayo Clinic Number. Per clinic year, February, 1932 to December, 1932, paper cover, $12.00; cloth cover, $16.00. W. B. Saunders Company, Philadelphia and London, 1932.

This is the Mayo Clinic number, and, as usual, contains many reports of interesting cases. Dr. Judd considers mesenteric cysts which are rare. Dr. Balfour presents unusual cases of the upper abdomen. Dr. Rankin demonstrates some cases of malignancy of the ovary, jejunum and the rectosigmoid. The production of speech by artificial means, after laryngectomy, is thoroughly discussed by Dr. Sheard and a much improved artificial larynx is described. The many advantages of transurethral resection of the prostate gland is presented by Dr. Bumpus, and a new instrument described. Dr. Mulholland suggests a unique method of applying a splint to the pendulous urethra. Further observations on spinal anesthesia are made by Dr. Lundy. There are numerous other subjects worthy of any surgeon's attention.

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SURGICAL CLINICS OF NORTH AMERICA (Issued serially, one number every other month). Volume 12, number 5. (Chicago number—October, 1932) Octavo of 268 pages with 61 illustrations. Per clinic year, February, 1932, to December, 1932, paper, $12.00; cloth, $16.00. W. B. Saunders Company, Philadelphia and London, 1932.

This volume covers a wide range of subjects of particular interest to the general surgeon as well as to the specialists. The subjects considered are: bone tumors, tuberculosis, fractures, use of radium, breech presentation, ureteral calculus, empyema, goiter, ruptured spleen, carbuncle of the kidney, fibroma of the lung, pericarditis, and cerebellar abscess. Dr. C. L. Martin, of the Mercy Hospital, presents an interesting series on cancer of the rectum and sigmoid. Most any surgeon can find something of value in a volume such as this.

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SURGICAL CLINICS OF NORTH AMERICA. Philadelphia Number—December, 1932. Volume 12, No. 6. Index number. 280 pages with 110 illustrations. Per clinic year (February, 1932, to December, 1932) paper, $12.00; cloth, $16.00. W. B. Saunders Company, Philadelphia and London.

In this number the contributors are members of the medical schools of Jefferson, Pennsylvania, and Temple Universities, and of the Woman's Medical College. There is a wide range of subjects covered with abdominal conditions taking the lead. Dr. Damon B. Pfeiffer presents some very interesting cases of carcinoma of the colon and rectum, stressing the choice of the operation appropriate to the case rather than having a standard procedure for all cases. Intestinal obstruction is well presented by Drs. Ryan and Block. Gastro-intestinal hemorrhage is discussed by Dr. E. L. Eliason and "Railway Spine" by Dr. Carnett. Dr. W. W. Babcock presents a series of cases exemplifying the amount of patience necessary in some cases to secure a satisfactory result. Infections in the dangerous circle of the face by V. W. Murray Wright should be read and heeded by every practitioner.

E. L. C.

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DIAGNOSIS AND TREATMENT OF DISEASES OF THE THYROID GLAND. By George Crile and Associates. 508 pages with 164 illustrations. Cloth. Price $6.50. W. B. Saunders Company, Philadelphia and London, 1932.

Dr. George Crile and his associates at the Cleveland Clinic present a symposium on the diagnosis and treatment of diseases of the thyroid gland which is one of the most important books to be published in 1932. These men, specialists in all fields of medicine, present dissertations on the thyroid in relation to the disturbances of the blood, heart, diseases of children, pulmonary tuberculosis, metabolic disturbances, laryngeal disturbances, diseases of the skin and the eye, joint conditions, and syphilis. The medical treatment and management of hyper- and hypo-thyroidism, and the role of iodine in prophylaxis and treatment is marvelously presented. The exact surgical technic, well illustrated, and pre- and post-operative

care, the end result of 22,441 operations is an extremely valuable contribution. Hyper and hypothryroidism affects every system of the body, thus all branches of medicine and surgery are called upon for diagnosis and treatment; thus, all physicians will want this book, for it is the most outstanding, up-to-date book of the year. Each chapter is followed by a complete bibliography, the book is beautifully illustrated and well indexed.

* * *

SYNOPSIS OF GYNECOLOGY. By H. S. Crossen, M.D., F.A.C.S., Professor of Clinical Gynecology, Washington University Medical School, and gynecologist in chief to the Barnes Hospital and Washington University Dispensary; and Robert J. Crossen, M.D., instructor in Clinical Gynecology, and Obstetrics, Washington University Medical School and gynecologist to St. Luke's and DePaul Hospitals. 227 pages with 110 illustrations. Cloth. Price $2.75. The C. V. Mosby Company, St. Louis, 1932.

This synopsis is based on the textbook "Diseases of Women" by Dr. H. S. Crossen. It is intended primarily for the medical student who generally has neither the money to buy nor the time to read the larger texts, and also for the physicians following other branches of medicine who need only a general knowledge of gynecology. The general practitioner and the gynecologist will find this book of value for it is a handy little pocket edition for reference to the subject. The authors have completely covered the subject in a thorough but brief manner. The diagnosis and therapy are well outlined and the book contains many instructive illustrations.

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A MANUAL OF PHARMACOLOGY AND ITS APPLICATION TO THERAPEUTICS AND TOXICOLOGY. By Torald Sollmann, M.D., Professor of Pharmacology and Materia Medica in the School of Medicine of Western Reserve University, Cleveland, Ohio. Fourth edition, revised. Octavo of 1,237 pages. Cloth. Price $7.50. W. B. Saunders Company, Philadelphia and London, 1932.

The value and demand for the "Manual of Pharmacology" is proven by its being in the fourth edition. It is used as a text of reference in teaching pharmacology to medical students in practically all medical schools. Because of its completeness it serves as a reference to special investigators, and is of especial interest to the practitioner for obtaining desired information. The author presents the current conception of the action of drugs from the standpoint of practical importance in medicine. In ordinary type he presents a fairly concise and connected story of the facts and explanations that deserve study for their direct bearing on medical practice, and in smaller type he gives data of less frequent use or of less importance. This arrangement is facilitated by paragraph headings. The references and the bibliography are complete and intended to guide the inquirer to further information.

The present revision has been restricted chiefly to the fields in which there has been definite advance. The changes include arsphenamine fate, barbiturates, bismuth, cincophen toxicosis, iodine compounds in roentgenology, liver extract, morphine addiction, fate of morphine, quinine, and plasmoquin, sexual hormones, temperature regulation, thallium, vitamines, etc.

* * *

THE SPUTUM, Its Examination and Clinical Significance, by Randall Clifford, M. D., Associate in Medicine, Peter Bent Brigham Hospital; Assistant in Medicine, Harvard Medical School; Formerly Associate Physician and Director of Pulmonary Clinic, Massachusetts General Hospital. Stiff-back binding; beautifully printed and illustrated; 152 pages. Price, $4.00. Publishers, The Macmillan Company, New York.

This is a most attractive book, beautifully illustrated. The subject matter is exceedingly important, especially inasmuch as too many doctors have been paying too little attention to the sputum as a means of clinical and laboratory diagnosis. The book is well arranged and seems authentic so far as we have been able to judge. At first glance the book will seem to be somewhat high in price. The reason is to be found in the numerous illustrations and the quality of paper made necessary by the illustrations. We do not recall having seen better color micrographs anywhere than are reproduced in considerable number. Halftones are also used in abundance and are unusually clear and helpful. A great many references are given at the end of each chapter. The index is unusually complete. We can strongly recommend the book in every particular.

CORRECTION OF DEFECTIVE SPEECH. A complete Manual of Psycho-Physiological Technique for the Treatment and Correction of the Defects of Speech; by Edwin Burket Twitmyer, Ph. D., Professor of Psychology and Chief of Corrective Speech Clinic, University of Pennsylvania, and Yale Samuel Nathanson, Ph. D., Instructor in Psychology and Assistant, Corrective Speech Clinic, University of Pennsylvania. Stiff-back binding; 158 pages; few illustrations; well printed; Publishers, P. Blakiston's Son & Co., Inc., Philadelphia, Pennsylvania. Price $3.50.

This is a book which is of interest, it seems to us, only to teachers who have as their responsibility the instruction of children suffering from speech defects. We do not understand why it was sent to us for review as it is clearly out of the province of the physician. Possibly the parent of a child with a speech defect might use this book in home instruction of the child but we seriously question if doctors would be capable of recommending exercises for that purpose unless the doctor had had special training in that work. This book is probably excellent in its proper place but is not intended for the use of physicians.

TRUTH ABOUT MEDICINES

FOODS

The Committee on Foods of the American Medical Association has accepted the following products for inclusion in Accepted Foods:

BRER RABBIT PURE SUGAR CANE SYRUP (Blue Label Grade) (Penick and Ford, Ltd., New Orleans).—Pasteurized "sugar cane syrup" prepared by evaporation of sugar cane juice; treated with sulphur dioxide.

DR. P. PHILLIPS PURE FLORIDA GRAPEFRUIT JUICE (Dr. P. Phillips Company, Doctor Phillips, Fla.).—Canned Florida grapefruit juice sweetened with added sucrose and claimed to contain in large measure the original natural vitamin content.

GERBER'S STRAINED CEREAL, LONG-COOKED IN MILK (Unseasoned) (Gerber Products Company, Fremont, Mich.).—Strained, cooked whole wheat, oats and wheat germ; cooked in milk. The coarse bran is strained out. It is claimed to be especially prepared for infant feeding, children, convalescents and special diets.

QUAKER WHITE CORNMEAL (The Quaker Oats Company, Chicago).—Fine granular white Indian corn cornmeal containing practically no bran or germ.

JACK SPRAT BRAND CRYSTAL WHITE SYRUP; KING KORN BRAND CRYSTAL WHITE SYRUP (Penick and Ford Sales Company, Cedar Rapids, Iowa, packer; Western Grocer Company, Marshalltown, Iowa, and branches, and A-S Wholesale Company, Plainview, Neb., distributors).—Corn syrup base (85 per cent) and sucrose syrup (15 per cent). (*Jour. A. M. A.*, January 7, 1933, p. 43).

QUAKER PEARL HOMINY (The Quaker Oats Company, Chicago).—Coarse cracked and pearled white Indian corn grits containing practically no bran or germ.

CORINNIS WAUKESHA PURE SPRING WATER (Hinckley and Schmitt, Chicago).—A bottled spring water of low mineral content practically free of micro-organisms.

JELL-WELL PLAIN GELATINE (Jell-Well Dessert Company, Ltd., Los Angeles).—Plain granulated gelatine claimed to be suitable for all table uses of gelatin and for special diets.

BRER RABBIT PURE NEW ORLEANS MOLASSES (Gold Label) (Penick and Ford, Ltd., New Orleans).—Pasteurized New

Orleans molasses taken from the first crystallization liquor in the preparation of cane sugar; treated with sulphur dioxide.

PRUDENCE BEEF STEW (Boston Food Products Company, Boston).— Canned beef stew containing cooked beef, potatoes, carrots, onions, salt and pepper.

ARBITRATOR PATENT FLOUR. PHOSPHATE ADDED (Bleached) (Saxony Mills, St. Louis).—Soft winter wheat patent flour with 0.5 per cent added monocalcium acid phosphate; bleached.

QUAKER YELLOW CORNMEAL (The Quaker Oats Company, Chicago).—Fine granular yellow Indian corn cornmeal containing practically no bran or germ.

GLADIOLA PATENT FLOUR (Matured, Bleached); FANT'S FAIRY PATENT FLOUR (Matured, Bleached) (Fant Milling Company, Sherman, Texas).—Patent flour milled from a blend of soft wheat and hard wheat; bleached.

UNION MADE BREAD. Long Loaf (Union Bakery Company, Sioux Falls, S. D.).—A white bread made by the straight dough method.

SUPERB BRAND AMBER SYRUP; GOLDEN RULE BRAND AMBER SYRUP (Penick and Ford Sales Company, Cedar Rapids, Iowa, packer; Tolerton & Warfield Company, Sioux City, Iowa, distributor).—Corn syrup base (85 per cent) with refiners' syrup (15 per cent). (*Jour. A. M. A.*, January 14, 1933, p. 116).

BRER RABBIT PURE SUGAR CANE AND CORN SYRUP (Brown Label) (Penick and Ford, Ltd., New Orleans).—A pasteurized mixture of sugar cane syrup (evaporated sugar cane juice) and corn syrup; treated with sulphur dioxide.

HECHT'S SALT RISING BREAD (Hecht's Bakery, Bristol, Tenn.).—"Salt rising bread" prepared by the sponge dough method; fermentation is due to other organisms than yeast. The flavor is claimed to be different from that of the usual white bread.

PRUDENCE READY TO BROWN CORNED BEEF HASH (Boston Food Products Company, Boston).—Canned corned beef hash; cooked corn beef and potatoes; seasoned with salt and pepper.

WHITE RIBBON FLOUR (Phosphate added) (The Scott County Milling Company, Sikeston, Mo.).—A blended "standard patent" flour milled from soft and hard red winter wheats, bleached and matured. It is designed for biscuit baking.

BRE RABBIT PURE NEW ORLEANS MOLASSES (Green Label) (Penick and Ford, Ltd., New Orleans).—Pasteurized New Orleans molasses taken from the second crystallization liquor in the preparation of cane sugar; treated with sulphur dioxide.

1. Sunrise Brand Tomato Juice. 2. Advo Tomato Juice. 3. Good Morning Tomato Juice. 4. Herald Brand Tomato Juice. 5. Kamo Brand Tomato Juice. 6. Daisee Brand Tomato Juice. 7. Krasdale Brand Tomato Juice. 8. Fleetwood Tomato Juice. 9. Approval Tomato Juice. 10. New State Brand Tomato Juice. 11. Pickwick Brand Tomato Juice. 12. 18-K Brand Tomato Juice. 13. The Rider Brand Tomato Juice. 14. Leslie Brand Tomato Juice. 15. Goodyear Brand Tomato Juice (Vincennes Packing Corporation, Vincennes, Ind., packer; 1. Miner, Read & Tullock, New Haven, Conn. 2. McCord Brady & Co., Omaha. 3. Good Morning Co-Operators, Terre Haute, Ind. 4. Mazo Lerch Company, Washington, D. C. 5. Paxton and Gallagher Company, Omaha. 6. The Herrman Company, Paterson, N. J. 7. A. Krasne, New York. 8. King, Dobbs & Co., Chattanooga, Tenn. 9. M. E. Horton, Inc., Washington, D. C. 10. The Williamson-Halsell-Frasier Company, Oklahoma City. 11. Kansas City Wholesale Grocery Company, Kansas City. 12. Winston and Newell Company, Minneapolis. 13. The Nicholas Reiter Company, Baltimore. 14. Cressey Dockham & Co., Inc., Salem, Mass. 15. Mazo-Lerch Company, Washington, D. C., (distributors).—Pasteurized tomato juice with added salt; claimed to retain in high degree the vitamin content of the raw juice. (*Jour. A. M. A.*, January 21, 1933, p. 186).

REAL BIG BOY BREAD (Sliced) (The Uffelmann Baking Company, Cincinnati).—A white bread made by the sponge dough method.

QUAKER HOMINY GRITS (The Quaker Oats Company, Chicago).—Coarse white Indian corn grits containing practically no bran or germ. It is claimed to be for all table uses.

JUANITA SHORT PATENT FLOUR (The Scott County Milling Company, Sikeston, Mo.).—A "short patent" soft winter wheat flour; bleached and matured; phosphated or not phosphated. It is intended especially for cake and pastry baking.

JACK SPRAT BRAND GOLDEN SYRUP; KING KORN BRAND GOLDEN SYRUP (Penick and Ford Sales Company, Cedar Rapids, Iowa, packer; Jack Sprat Foods, Inc., Marshalltown, Iowa, and A-S Wholesale Company, Plainview, Neb., distributors).—A table syrup with a corn syrup base (85 per cent) with refiners' syrup (15 per cent).

1. Red Cross Brand Sterilized Unsweetened Evaporated Milk. 2. Gold Cross Unsweetened Sterilized Evaporated Milk. 3. Northfield Brand Sterilized Unsweetened Evaporated Milk. 4. Columbine Sterilized Unsweetened Evaporated Milk (1. Colorado Condensed Milk Company, Fort Lupton, Colo.; 2. Mohawk Milk Products Company, New York City; 3. Northfield Milk Products Company, Northfield, Minn.; 4. Colorado Condensed Milk Company, Fort Lupton, Colo.; subsidiaries of the Carnation Company, Milwaukee).—Unsweetened sterilized evaporated milk. (*Jour. A. M. A.*, January 28, 1933, p. 259).

PROPAGANDA FOR REFORM

HAZARDS OF IODIZED OIL INJECTIONS.—It has been ten years since Sicard and Forestier introduced into medical practice the iodized oils as diagnostic agents. These appeared to offer great possibilities in the localization and definition of certain lesions in the cavities of the body. Occasionally incidents have been reported showing that the injection and retention in the body of these oils are not without danger. In a recent issue of THE JOURNAL, December 3, 1932, p. 1946, appeared a report of the Council on Pharmacy and Chemistry dealing with the dangers of the injection of iodized oils. The report emphasized anew the necessity for a policy which has guided the Council in its deliberations over the past quarter of a century; namely, that of insisting on due caution in the use of all new methods and preparations until their potentialities for doing damage have been subjected to the test of scientific scrutiny. (*Jour. A. M. A.*, January 7, 1933, p. 46).

MISBRANDED "PATENT MEDICINES".—The following "patent medicines" have been the subject of prosecution by the Food and Drug Administration of the U. S. Department of Agriculture which enforces the Federal Food and Drugs Act: Goldban's Celebrated 449 Remedy (Hance Bros. and White, Inc.), containing potassium nitrate, methenamine, uva ursi, alcohol and water. Iroquois Famous Indian Herb Tea (Iroquois Famous Indian Remedies Co., Inc.), containing coriander, fennel, celery, senna, buchu, chamomile, sassafras and triticum. Soak-In Liniment (Morgan and Sampson), chiefly oils, including methyl salicylate (49 per cent), and peppermint. Novak's Kidney Pills and Komet (John Novak Co.): The pills containing methylene blue and cubeb oleoresin; the Komet, an ointment essentially of petrolatum base containing methyl salicylate, camphor and menthol. Bel-Rub (W. E. Shuit, Inc.), an ointment with a petrolatum base containing methyl salicylate, camphor and menthol. Davis' Union Tonic (Charles T. Davis), containing epsom salt, with extracts of plant drugs, including licorice, a laxative, a bitter, salicylic acid and water. Myer's (Dr.) Pneumonia Compound (Myers Remedy Co.), containing sodium salicylate, extracts of plant drugs, sugar, alcohol and water. Diatussin (Ernst Bischoff Co., Inc.), containing extracts of plant drugs including thyme, with alcohol and water. Histosan Syrup (Ernst Bischoff Co., Inc.), containing guaiacol, protein matter, sulphates, sugar and water. Metro-Oil (Metro-Oil Co.), containing mineral oil, volatile oils including rose oil, and a small amount of pyridine. Wampole's Vaginal Cones Boroglyceride Compound with Ichthyol (Henry K. Wampole and Co.), containing boric acid, borax, zinc and sulphonated compounds, gelatin and glycerin. Bee Brand Laxative Quinine Tablets (McCormick and Co.) containing acetanilid (1.9 grains per tablet), cinchonin, caffeine, podophyllum resin and a trace of quinine. Ferrosanol (Haemozon Products Co.), containing common salt, hydrochloric acid, iron (ferrous and ferric) salts and water. K P N Nutrition No. 50 and K P N Nutrition No. 75-25 (Perfect Nutrition Co., Inc.): No. 50 being essentially a mixture of alfalfa, beets, parsley, and seaweed; No. 75-25 essentially a mixture of beets and kale. R 5000 (Robert P. Gust Co., Inc.), containing extracts of plant drugs including a laxative drug, trace of alkaloids, resins, aloin, alcohol and flavored water. Eucaline Tonic Compound (Eucaline Medicine Co.), containing cinchona

hydrochloride, iron chloride, a laxative plant drug, sugar, alcohol and water; the "tasteless" form had essentially the same composition, with the addition of acetanilid. Mygrone (John Wyeth and Bro., Inc.), containing amidopyrin and fillers. Boracetine (F. E. Barr and Co.), containing baking soda, sodium borate, potassium chlorate, thymol, menthol, eucalyptol and cassia oil, alcohol and water. Romineck's Diuretic Pills (Hance Bros. and White, Inc.), containing extracts of plant drugs including licorice, bearberry, buchu and juniper oil. Monroe's Formula No. 7 (Dow Drug Co.), essentially iron and ammonium citrate, sodium benzoate, potassium iodide, very small amounts of hydrastis, with glycerin and water. Kavatone (Gray's Medicine Co.), containing potassium iodide, a laxative drug, sassafras oil and methyl salicylate, isopropyl alcohol, glycerin and water. Blue's (Dr.) Kidney and Bladder Remedy and Dr. Blue's Wonderful Blood Purifier (James T. Blue Chemical Co.): Kidney and Bladder Remedy was essentially methenamine, potassium acetate, buchu, sugar, alcohol and flavored water; Blood Purifier was essentially epsom salt, potassium iodide, sodium salicylate, and sassafras, with water and vanilla flavoring. Beach's Gen-Sen Tonic (Beach's Wonder Remedy Co.), essentially baking soda, common salt, saccharin, volatile oil including cassia, menthol and methyl salicylate, alcohol, water and a trace of borax. Oxien Nazone Salve (Great Oxie Co.), an ointment with a petrolatum base, sassafras oil, camphor oil, methyl salicylate, and traces of carbolic acid and menthol. T. M. C. Laxative Cold Tablets (Frederick Stearns and Co.), containing acetanilid, cinchonine salicylate, podophyllum and camphor. C. P. R. Tablets (P. McConnel Co.), containing aspirin, acetphenetidin, a laxative drug, and red pepper. Standard Cough and Cold Compound (Standard Remedy Co., Inc.), essentially tar, menthol, extracts of plant drugs including wild cherry; salicylic acid, sulphuric acid, glycerin, sugar and water. Standard System Tonic (Standard Remedy Co., Inc.), containing epsom salt, salicylic acid, saccharin, licorice, sassafras, wild cherry and water. Welch's Aegopodium (W. C. Welch), containing potassium iodide, colchicine, alcohol and water. Adropsedema (Van Seaton Chemical Co.), containing metallic iron, scoparius and gelsemium. Leonard's Elixir (S. B. Leonardi & Co., Inc.), containing potassium iodide, extracts of plant drugs, small quantity of an iron compound, alcohol, sugar and water. Chewalla (Chewall Co.), containing potassium iodide, acetic acid, a laxative drug, alcohol and flavored water. Four-Forty-Four (4-44) (W. B. Nethery), containing epsom salt, compounds of ammonium, sodium, potassium and phosphorus, small quantities of saccharin and salicylic acid, traces of calcium, iodine and manganese, sugar and water, flavored and colored. (*Jour. A. M. A.*, January 7, 1933, p. 58).

DR. STOLL'S DIET-AID.—Several inquiries have been received within the past year regarding "Dr. Stoll's Diet-Aid, the Natural Reducing Food." The address of Diet-Aid, Inc. is also the address of Dr. John E. Stoll, who, according to our records, was born in 1900, was graduated by Rush Medical College, Chicago, in 1925, and licensed in Illinois the same year. In reply to an inquiry addressed to Dr. Stoll he stated that Diet-Aid is intended to be taken in the form of a beverage by those on a reducing diet, and is a compound of milk chocolate, starch, and a water extract of roasted whole wheat and bran; that Diet-Aid has the following composition: carbohydrates, 75.5 per cent; crude fat, 3.6 per cent; crude protein, 9.2 per cent; ash, 5.6 per cent; moisture, 6.1 per cent. Dr. Stoll also stated that in making the ordinary drink of Diet-Aid, one level teaspoonful was used in a cup of water. This weighs about 3 grams, and in view of the composition of Diet-Aid, would give almost 11 calories (10.89) in all, in a cup of Diet-Aid. In this connection, it is worth remembering that a tablespoonful of whole milk has a fuel value of 14 calories. According to the directions on the trade package, the person is told to substitute "one or more cups" of Diet-Aid in the place of breakfast and lunch. The average sedentary woman's daily fuel requirements range from 1,800 to 2,300 calories. The breakfast for such a woman would call for caloric values ranging between 400 and 600. According to Dr. Stoll's plan, such a woman would take "one or more cups" of Diet-Aid having a fuel value of less than 11 calories to the cup, of which 9 calories would be carbohydrate. The same would be true for the luncheon. The person who follows the Diet-Aid suggestion must inevitably receive a hopelessly unbalanced diet. (*Jour. A. M. A.*, January 21, 1933, p. 207).

NEOCAINE.—One original package of Rachi-Néocaine Corbière (Laboratoires Pharmaceutiques Corbière, Paris; Sole U. S. Agents, the Anglo-French Drug Company, Inc., New York) was submitted to the A. M. A. Chemical Laboratory for preliminary examination. Qualitative tests indicated the presence of procaine base (para-aminobenzoyl-diethylaminoethanol) and chloride. On thermal analysis the specimen was found to be identical with procaine hydrochloride U. S. P. Neocaine appears therefore to be the French proprietary name for procaine hydrochloride. The product has not been submitted to the Council on Pharmacy and Chemistry for inclusion in New and Non-official Remedies. (*Jour. A. M. A.*, January 21, 1933, p. 210).

BANCROFT'S THIOCYANATE THERAPY.—Recently THE JOURNAL referred to Bancroft's method for the control of narcotic addiction and of the effects of anesthetic drugs. Choosing sodium thiocyanate—also designated rhodanate by some chemists—as the peptizing agent, the Cornell University chemists believed that the sensory nerve colloids are albumin-like and should absorb the thiocyanate ion strongly and be easily peptized by the cell electrolytes. The experiments have recently been criticized as unconvincing by Burkholder of the department of pathology at the University of Chicago. His results obtained with sodium thiocyanate as an antagonist for ether did not corroborate the conclusions brought forth by Bancroft and Rutzler that thiocyanate ions antagonize the anesthetic action of ether. In a large majority of the experiments with ether the return to normal of the lid reflexes and other manifestations required a longer time in these experimental animals than in their controls. As an antagonist for sodium amytal it was found that the sodium thiocyanate did not shorten the long anesthesia but instead lengthened it, and decreased instead of increased the respiratory rate. As an antagonist for morphine it was found that the morphine narcosis was not counteracted in any way and that gradient reduction in the dosage of thiocyanate still proved fatal or toxic. Such a recital of actual attempts to corroborate Bancroft's results warns against undue exploitation of a drug of which the pharmacologic effects are by no means conclusively established. (*Jour. A. M. A.*, January 28, 1933, p. 262).

THE FEDERAL TRADE COMMISSION.—At various times attention has been called to the good work that is being done by the Federal Trade Commission in protecting the public against misrepresentation or fraud in the medical or quasi-medical fields. Congress has given this Commission power to investigate and take action on cases that involve or that seem to involve what are broadly spoken of as unfair trade practices. Where such investigations prove that unfair trade practices have been indulged in, the Commission can, and in many instances does, obtain from the individual or concern involved a signed stipulation to the effect that the objectionable methods will be abandoned. If a stipulation cannot be arrived at, the Commission may issue what is known as a Cease and Desist Order, in which the person or concern involved is ordered to cease and desist from the objectionable practices. A few of the many cases reported in the Commission's bulletins in the past few months were: Marvo (William Witol and Marvo, Inc., New York City).—The firm has agreed to discontinue representing that Marvo will, within three days' time, remove pimples, blackheads, crow's-feet around the eyes, wrinkles, etc. It appears that Witol's Marvo had at one time as its active caustic ingredient salicylic acid. Later resorcin seems to have been the active ingredient. Reports have been received from physicians of severe reactions suffered by patients who had used the Marvo product. Hildebrand Laboratories.—Frank Granzow of Chicago, whose trade name is "Dr. Hildebrand Laboratories," sold an alleged treatment for gallstones, stomach trouble, nervousness, jaundice and constipation. He has agreed to discontinue representing that his treatment will cure the ailments specified, when such is not the fact. The Hildebrand product has been reported to contain menthol, oleic acid, phenolphthalein, powdered gentian, castile soap and sodium salicylate. Goldman Hair Dye (Monroe Chemical Company, St.

Paul).—The concern has agreed to discontinue representing that the dye will "restore" the color of the hair, that the treatment takes only seven or eight minutes and requires only a few cents' worth of dye, and that the gray hair regains its youthful color overnight, when such are not the facts. The product is a hair dye of the silver-salt type. Cystex (The Knox Company, Kansas City, Mo.).—The Knox Company has agreed to discontinue making false and misleading claims for its nostrum. Cystex, it seems, comes in the form of two tablets, gray and brown. A few years ago the gray tablets were said to contain hexamethyleneamine, powdered extracts of colchicum, calcium phosphate, and thyroid substance. Later, reference to thyroid substance was omitted. The brown tablets have been claimed to contain extracts of hydrangea, corn silk, buchu and triticum, with boric acid, potassium bicarbonate and atropine sulphate. Lepso—A mailorder epilepsy cure put on the market by R. P. Neubling of Milwaukee, doing business under the trade names R. Lepso and Lepso Company. Neubling has agreed to discontinue his claim that the stuff can be taken safely by children, when such is not the fact, and also to cease claiming that the product is a competent treatment for epilepsy without indicating the limits of its effectiveness. The product, at the time it was examined in the A. M. A. Chemical Laboratory, was found to contain the equivalent of 51 grains of potassium bromide to the dose. Dermolax.—H. G. Levy, who traded as the Interstate Laboratories of Chicago, has agreed to discontinue representing that psoriasis is caused by a germ localized in the tissues of the skin and that Dermolax Ointment and Soap would reach the seat of the trouble, when such is not the fact. He has also agreed to cease representing that Dermolax is a specific treatment for psoriasis. Information received by the Bureau of Investigation in 1929 was to the effect that the Dermolax "treatment" consisted of a white product containing ammoniated mercury and a brown preparation that contained chrysarobin. (*Jour. A. M. A.*, January 28, 1933, p. 275).

ABSTRACTS

THE INFANT LARYNX: DIRECT LARYNGOSCOPIC OBSERVATIONS

GABRIEL TUCKER, Philadelpia (*Journal A. M. A.*, Dec. 3, 1932), states that the infant larynx has certain fundamental peculiarities of structure that must be considered in its examination and treatment. Complete examination can be made only by the direct method. The difficulties of the examination are more apparent than real if the proper preparation, instruments and technic are used. The technic of direct examination of the larynx as perfected by Jackson is practical and can be acquired by any otolaryngologist because it is based on anatomically correct principles. In supraglottic tracheoscopy, the following modification of technic is suggested: When on inspection of the subglottic larynx a lesion is found, an infant bronchoscope is used for exploration of the larynx, subglottic larynx and trachea. If the condition is producing urgent dyspnea and a tracheotomy is required, the infant bronchoscope is passed through the larynx into the trachea, immediately relieving the dyspnea. It is left in position during tracheotomy and serves as a guide; it converts an emergency operation into an orderly one, thereby conserving the laryngeal structure and eliminating morbidity and possibly mortality. Two types of infant bronchoscope have been devised, with an inside full lumen of 3.5 and 4 mm., respectively, and an outside diameter equal to 18 and 20 French scale. These small tubes can be passed through the subglottic larynx in normal new-born infants without trauma. The most important measurement in the infant larynx is the subglottic diameter. Tracheotomy conserves the laryngeal structure better than intubation in infants. Symptoms of laryngeal disease in infants are frequently disregarded until serious secondary complications develop. Inspection of the larynx by the laryngologist will permit a correct diagnosis and save the lives of many infants.

HEAVILY FILTERED HIGH VOLTAGE ROENTGEN IRRADIATION IN CANCER THERAPY

WALTER L. MATTICK, Buffalo (*Journal A. M. A.*, Dec. 24, 1932), outlines briefly his experiences of the past four years with what he characterizes as a type of short wavelength therapy, previously referred to as protracted radiation, carried on with the usual 200 kilovolt x-ray equipment in which heavy filtration (3 mm. of copper) has been substituted for the usual 0.5 mm. of copper as commonly used in the average routine roentgenotherapy of the present day. During the past four years he has administered approximately 500 such treatments to fifty-two patients with various types of malignant growths. Most of these cases were far advanced or of the ordinarily refractory types. In this category are included the following: forty-two patients with cancer of the breast (mostly far advanced), four with cancer of the larynx, four with cancer of the esophagus, one with epithelioma of the oral cavity and one with epithelioma of the cervix (far advanced). In evaluating the results thus far attained the author is in full accord with Schreiner, for many years chief surgeon at the State Institute, who refers to this heavily filtered shorter wave roentgen and teleradium therapy as the most promising types so far advanced, besides having decided advantages in treatment and producing quite similar results on the malignant conditions in which it has so far been used.

CHRONIC URINARY INFECTION IN INFANCY AND CHILDHOOD

MEREDITH F. CAMPBELL, New York (*Journal A. M. A.*, Dec. 31, 1932), points out that because infection of the urinary tract so frequently complicates bacterial processes elsewhere, it is one of the commonest diseases of children and, in patients under 2 years of age, probably outranks any other. When the urinary infection is neither self-limited nor therapeutically cured within a period of from four to six weeks, the persistent pyuria quite regularly leads to the erroneous or inadequate diagnosis of chronic pyelitis or chronic cystitis. In these cases the inadequacy of the diagnosis pyelitis or cystitis is comparable to that of laryngitis when the disease is chronic pulmonary tuberculosis. The author demonstrates that (1) chronic pyuria is seldom the sign of an uncomplicated disease, (2) demonstration of the associated etiologic factors regularly requires complete urologic examination and (3) frequently urologic surgical treatment is demanded to control the infection or to save life. The clinical data he records were obtained by personal complete urologic examination of 274 juveniles with chronic pyuria. Nearly all were referred for investigation with the diagnosis chronic pyelitis. Under the diagnosis of chronic pyelities or chronic cystitis infants and children are commonly and unsuccessfully treated for months or years. When renal infection exists, the lesion is basically suppurative pyelonephritis. In many cases of "pyelitis," the infection is localized to the bladder and urethra. When chronic urinary infection resists intensive medical treatment for one month, a complete urologic examination is indicated. Only by this method can the correct diagnosis be established. In infants and children one may find almost every lesion of the urinary tract which one is accustomed to associate with adult life. As a rule, medical therapy alone is inadequate to effect a bacteriologic cure and, while surgical attack may serve only to control rather than to cure the infection, conservative operations will often prevent further renal destruction and thus prove life saving. Occasionally, nephrectomy is demanded. While urology in children is yet a virgin field, the striking accomplishments of its many workers actively challenge the almost universal resistance to practitioners in general and pediatricians in particular to the employment of recognized urologic methods of diagnosis and treatment when the patient is a child.

DOCTOR AND PATIENT

Modern medicine, strongly oriented toward the objective evidences of disease and toward their explanation on a physical basis, has abundantly justified its attitude by the advance it has made in the diagnosis and treatment of organic disease. This advance, however, together with the specialization it has developed, has tended toward a depersonalization of the practice of medicine and toward concentrating attention on the disease rather than on the patient. An instinctive resistance toward this tendency has been widely manifested and there is continued insistence that the practice of medicine involves a personal relationship between the physician and his patient that cannot be obviated. In the absence of a clearly stated rational basis for this point of view or a definite understanding of why this personal relationship might be of importance, the case has at times been weakened by a retreat to the grounds of sentiment.

In the meantime, psychiatry has been steadily advancing its understanding and treatment of the neuroses. With this progress there has been an increasing appreciation of the importance of the doctor-patient relationship in the prevention and treatment of the neuroses and of the neurotic concomitants of organic disease. It is now well established that in the relationship which exists whenever a patient reposes confidence in his physician there are large potentialities for good but that, in common with other potent agencies, the doctor's influence on his patient may result in harm if misused. The physician who carries his patient through serious physical illness without psychic damage, who practices a form of "preventive psychiatry" by which mental upsets are avoided, or who successfully helps his neurotic patients to understand themselves is making the best use of the relationship on which the psychiatrist depends for his expert psychotherapy. The physician, however, who provokes the onset of serious neuroses by ill-considered observations or who leads his patient into an unprofessional relationship by the nature of his psychotherapy is productive of much harm to his patients.

Recognition of the importance of the personal relationship between physician and patient does not decry the accomplishments of modern medicine in its advance on the purely physical elements of disease. Modern medicine, which embraces illness of the mind as well as of the body, must recognize that roentgen diagnosis of gallstones and their surgical removal, for example, constitutes but one phase of the practice of medicine. Disease may be diagnosed and treated impersonally; the patient, however, is a human being, subject to mental as well as physical ills, and this human being must be the first object of consideration.

Thus an instinctive belief in the value of a time honored tradition, temporarily eclipsed by an impressive advance in another direction, now finds its justification on the basis of new advances. The practice of medicine, perhaps unbalanced for a time toward the physical side, will make its adjustments as it has in the past, will recognize the significance of mental factors and will consolidate the advances in both directions.—*Journal A. M. A.*, Aug. 13, 1932.

COLLAPSE MEASURES FOR PULMONARY TUBERCULOSIS: A STUDY OF THEIR RELATIVE APPLICABILITY

According to G. L. LESLIE, Howell, Mich. (*Journal A. M. A.*, Feb. 4, 1933), the majority, not the minority, of cases of active pulmonary tuberculosis are suitable for collapse therapy in some form. Considerable tuberculosis involvement of the better lung, even with cavities present, does not necessarily contraindicate collapse therapy. A comprehensive program of collapse therapy should emphasize the importance of beginning treatment in the minimal and moderately advanced stages of phthisis. Such treatment should be instituted by the trained physician in charge of the patient as soon as indicated after diagnosis and should not be dependent on early admission to a sanatorium whose waiting list may be a long one. The intensive development of postgraduate instruction will help to make such an objective possible.

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ORIGINAL ARTICLES

DIAGNOSIS AND TREATMENT OF ALLERGIC CONDITIONS AND CHRONIC INFECTIONS OF THE RESPIRATORY TRACT IN CHILDREN*

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INDIANAPOLIS

Perhaps the most common problem which confronts the pediatrician today is that concerning sinus disease and its complications. How often do we encounter the child, regardless of age, environment, and parents, who repeatedly appears with some nasal pathology known as sinus involvement, accompanied or not by one or many complications in other parts of the body? I speak of the child with repeated attacks of respiratory infection who sooner or later, due to recurring attacks, comes to us with either a bronchitis, bronchial pneumonia, bronchiectasis, or a host of other complications.

Like all diseases, our first step is to make a diagnosis, and then to apply treatment. It is my purpose briefly to review and summarize some of the newer opinions concerning the problem, and to formulate an outline which may be followed in any attempt to study and treat this group of cases.

The classification of the inflammatory diseases of the para-nasal sinuses, as given by authoritative otolaryngologists, has been accepted for a long time. Three main groups or types are considered: (1) Suppurative sinusitis; (2) Nonsuppurative, hyperplastic, or catarrhal sinusitis; (3) a combined type or suppurative-hyperplastic sinusitis. According to this classification, no distinction is made between allergic and non-allergic sinus disease. It is apparent, however, that non-suppurative-hyperplastic sinusitis is really allergic sinusitis. In the combined group, the allergic must be distinguished from the non-allergic. Suppurative-hyperplastic sinusitis may be either allergy with secondary infection, or true primary suppurative sinusitis with secondary hyperplasia. This point should be emphasized, as it is frequently forgotten during the prolonged treatment that these cases require. Nasal polypi may occur in both types. They occur more frequently and abundantly in allergy than in primary infections. We must recognize them therefore, as occurring primarily in one instance as a result of allergy, and in the other as a result of infection.

* Presented at the annual session of the Indiana State Medical Association, Michigan City, September, 1932.

ETIOLOGY

There are a great many schools of thought concerning the etiology of sinus disease, and one can but mention a few. There is a large school of workers who describe all their findings as due to local infection. Many reports in the literature have to do with the treatment and removal of these local infections[1], each showing beneficial results. There is another school that wishes to explain all findings, symptoms, and improvements as due to allergy. Haseltine[2] explains the condition as a toxic condition, plus an irritation of a reflex arc which has a sensitive center in the nose. A vast amount of work has been done on a relation of food to these diseases. The work of Daniel[3] and the Iowa group has clearly demonstrated the influence of certain vitamines as an etiological factor of sinus disease. Other workers have attempted to explain the whole problem on the basis of chemical reactions of the body tissues and fluids.[4] A large amount of interesting work has been done on this study of calcium metabolism as an etiologic factor in the production of this condition.

We might summarize by quoting from a symposium reported, in which Dr. George B. Blake[5] said: "Under the best of circumstances, the orthodox views regarding asthma and sinus infection are so chaotic and, at times, contradictory, and the results of treatment by the more or less standardized method are so irregular, unpredictable, and generally unsatisfactory, that only an almost fanatical enthusiast would maintain that we have reached the ne-plus-ultra in connection with this distressing malady."

LOCAL FINDINGS AND EXAMINATION

In primary sinus infections there is a striking absence of vaso-motor symptoms. The mucous membranes appear fiery red and inflamed. (So called "acid nose.") Polypi, if present, appear infected and more firm and compact than seen in allergy.

Examination of the allergic nose reveals changes which are quite different and very characteristic

in appearance. The membrane appears discolored, a greyish-pink (not red) with all degrees of swelling or edema. The edema is particularly apparent in the middle meatus and ethmoid region. In cases of long standing, marked polypoid formation may be observed.

The nasal manifestations of allergy are characterized symptomatically by sneezing, nasal obstruction, and nasal discharge. In non-seasonal

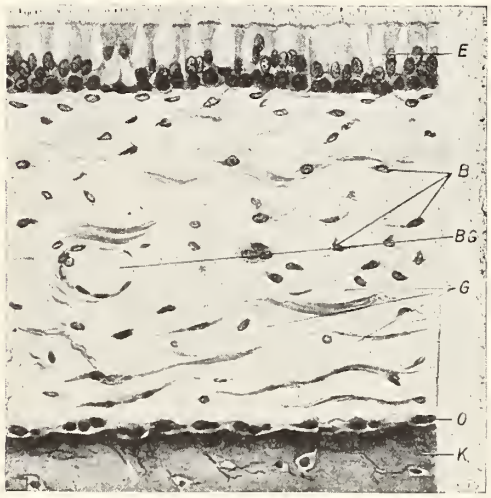


Fig. 1. Normal mucous membrane of the ethmoid cells (x 310). *E*, epithelium connective tissue cells; *BG*, blood vessels; *G*, tissue spaces; *O*, osteoblasts; *K*, from Hajek: Nasal Accessory Sinuses.

types they are generally intermittent, vary considerably in degree, and are apt to be confused with frequent colds of infectious origin. Allergic nasal reactions vary in duration from several hours to several days, but the attacks do not correspond to those of acute rhinitis, in which there is a constitutional reaction to infection and discharge of pus from the nose.

The study of the nasal discharge in allergy varies from a thin, serous liquid, to thick, tenacious mucus. The microscopic examination of the mucus shows a characteristic eosinophilia, as is noted in the bronchial secretions of asthma. Dean[6] has developed a simple technique for preparing these smears. By the use of small telescoped glass canulæ, enclosing a sterile cotton swab, he is able to reach high into the middle meatus, and obtain a pure smear (Wright stain). The St. Louis Clinic reports that a high percentage of hypersensitive cases shows a marked increase of easinophiles in the nasal smear. A recent case of ours showed as high as seventy-eight per cent. Smears made from patients with acute rhinitis show a large number of polymorphonuclear leukocytes as the predominating cell. Many workers lay great stress on this procedure as a point to differentiate the allergic group from non-allergic group of sinus cases.

Histopathologic Examination

Hansel[7] and his workers have made a careful histopathologic examination of the tissues in primary infection. The sinuses show, in addition to hyperplasia of the surface epithelium consisting of polymorphonuclear leukocytes, round cells, and plasma cells.

Dean[8] and his workers have beautifully shown the effects of infection on the epithelial lining of the nose in allergy. They have pointed out that the mucosa becomes very edematous, and that the cilia become inactive and are lost. Under normal conditions these cilia keep the sinuses free of secretions and bacteria. With the marked edema occurring in infections, stagnation of the secretions readily occur, and with repeated attacks of acute infections, a definite suppurative process may become active, and may eventually result in chronic infection. (See figures 1 and 2.)

Roentgenographic Examination

In order to study any case of sinus infection, one must have complete roentgenographic examination. Kern and Schenck recently reported that sixty-seven per cent of all asthmatic conditions showed positive x-ray findings. These authors concluded that positive roentgenray findings do not imply clinically active disease, and that clinical examination frequently overlooks chronic disease. Transillumination by most authorities is reported as very unreliable, unless other diagnostic procedures are used at the same time. From the x-ray examination, various degrees of thickening of the sinus mucous membrane, or the presence of polypi, may be determined. The roentgenographic examination of the para-nasal sinuses in allergy frequently shows varying degrees of opacity, depending upon the degree of pathologic change present. Allergic sinuses will often show a peculiar outfolding of the mucous membrane into the lumen of the sinuses. No study of these sinuses can be complete without the use of lipiodol injection. Proetz[9] has very definitely shown how transitory edema may give positive findings at one time and negative at another. With this in mind it is often necessary to have repeated roentgenographic examinations made of the sinuses.

On the basis of clinical histopathological and x-ray observations, it is apparent that the allergic sinus cases, with or without secondary infection, should be distinguished from the true infections, or primary suppurative sinus disease. Many of the disappointments in the treatment of the sinus disease have been the result of the failure to make this distinction.

Many of the chronic sinus infections follow in the wake of an allergic process, in which an edema of the mucosa has occurred. In these cases a careful history will usually disclose the previous existence of symptoms and other manifestations of allergy. In cases of doubtful diagnosis, Hansel states that one should not hesitate to remove tissue for microscopic diagnosis.

Other points in the differential diagnosis of nasal and sinus allergy is further established by the occurrence of other allergic manifestations in the same patient; a positive family history of allergy, the presence of positive skin tests, and eosinophilia.

One must again remember that any pathological condition of the nose and sinuses resulting from

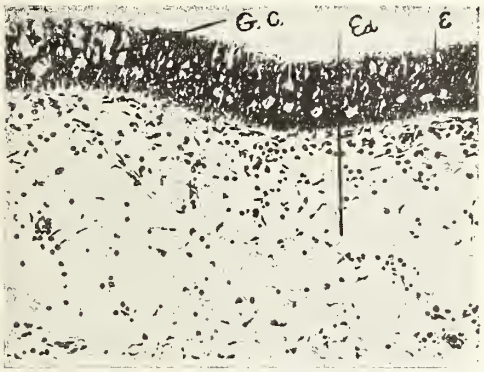


Fig. 2. Section of ethmoidal mucous membrane with early edema, beginning hyperplasia of epithelium and degeneration of goblet cells. Loose edematous stroma with eosinophiles and lymphocytes. *GC*, goblet cells; *Ed*, edema; *E*, epithelium.

allergic disease prepares the soil for secondary infection.

Treatment

In discussing the treatment of hyperplastic sinusitis and allergic phenomena of the sinuses, one must point out that there is no one single form of treatment in itself that is always effective. Only by careful consideration of all the factors entering upon this rather common but obscure condition, can one hope to obtain any definite result. It is often necessary to combine many different forms of treatment to obtain the desired results.

1. *Infection.* Infection has been considered in the past as an important etiologic factor. Many needless operations have been performed without definite benefit to the patient. We need only to mention again that the etiology of the "common cold" is not definitely established. As I have mentioned elsewhere, Dochez[10] and others have pointed out the role of the filtrable virus in the production of the common respiratory infections. Until this etiologic factor is definitely worked out, little hope can be expected from the use of our present-day measures to prevent recurring nasal infections.

2. *History.* A most complete and detailed history must be taken before any satisfactory results can be obtained. Much helpful information can be obtained from the patient.

1. COMPLAINTS:

Rhinitis	Eczema
Sneezing	G. I. upsets
Polyps, etc.	Headache, character
Lacrymation	Migraine
Burning, itching of eyes	Epilepsy
Asthma	Frequent colds
Urticaria	Food poisoning
Dermatoses	

2. FAMILY HISTORY:

Eczema	Asthma
Hay fever	Food poisoning

3. IMMUNIZATION HISTORY:

Smallpox vaccination	Horse serum, etc.
Typhoid vaccination	Pollen extracts
Toxin antitoxin	Food extracts
Whooping cough	Diphtheria antitoxin
ACTIVE. Autogenous vaccines	Tetanus antitoxin
"Cold" vaccines	PASSIVE. Scarlatine antitoxin
Foreign protein	Convalescent serums

4. PAST HISTORY:

TBC contacts	Whooping cough
Pneumonia	Measles
Pleurisy	Scarlet
Lung abscess	Rubella
Sinus infections	Smallpox
Chronic ears	Chickenpox
Quinsey	Diphtheria
Appendicitis	Erysipelas
Pyelitis	Miscellaneous
Tonsillitis	Cystitis

5. PRESENT TROUBLE:

Date of onset:
Seasonal:
Nonseasonal:
Perennial:
Duration:
Longest period free:
Ever change climate:

FOOD ASSOCIATIONS:

Strawberries, eggs, oatmeal, fish, etc.

EPIDERMAL ASSOCIATIONS:

Horse, cattle, dog, feathers, etc.

TRADE ASSOCIATIONS:

Cedar	feathers
dyes	glue
renovators	wool
boxwood	flour (baker)
furs	dust

MISCELLANEOUS ASSOCIATIONS:

Face powder, tobacco, etc.

DRUG ASSOCIATIONS:

Aspirin	picric acid
bichloride	coal tar, etc.
quinine	iodine

PLANT AND WEED ASSOCIATIONS:

Ragweed	hay
primrose	sumac
poison ivy	marigold
goldenrod	

6. TYPE OF ATTACKS: Describe them:
7. METHOD OF RELIEF: What relieves the attacks:
8. EFFECT OF CLIMATIC CONDITIONS:

Does high humidity precipitate an attack?
Are you worse preceding a storm?
Does fog make you worse?
Does southwest or west gale have any effect?

9. SEQUENCE OF EVENTS:

Infantile eczema	Duration	Duration
Hay fever	age	"
G. I. upsets	"	"
Asthma	"	"
Bronchitis	"	"
Bronchiectasis	"	"
Myocarditis	"	"
Dermatoses	"	

10. PREVIOUS DIAGNOSIS:
Who Where
11. PREVIOUS TREATMENTS:
Who Where
Nose or throat operations: Results:

3. *Allergy.* Where allergy is the fundamental etiologic factor, satisfactory results are dependent upon its treatment and control. One must fully understand the relation of foods, chemicals, and pollens, to the production of allergy. One must be equipped to perform the skin tests, and to evaluate their results. Skin tests may show a suspicious offending substance, but it must be remembered that they do not always reveal all of the specific etiologic factors. It may be said that skin tests, when negative, do not always mean that the given patient is not sensitive to a suspicious offending substance. When one is suspicious of an offending substance, such as food, elimination and trial diets are of special value. The evaluation of skin tests and trial diets requires that the physician become overly enthusiastic in regarding these substances as a true etiologic factor in the production of disease. It is my opinion that those working with allergy alone are too often prejudiced by the occasional case which is benefited or cured by the simple removal of some substance, like egg, dusting powders, etc. Duke[11] has done much to call our attention to certain physical agents, such as cold, heat, and smoke, in the production of allergic disease.

In those cases where sensitization factors have been definitely found, the treatment consists of desensitization. It is best to avoid contact with the offending protein. When this is not possible, then desensitization as used for example, in hay fever, may be employed.

4. *Vaccines.* The question of bacterial sensitization and the result of its use in the treatment of sinus and allergic conditions, is a very debatable one. Recently Mitchell[12] and Cooper have reported excellent results in a series of cases from the vaccine treatment of asthmatic conditions. Walker[13] has reported very encouraging results in patients, especially children subject to sinus and asthmatic diseases associated with cold, who were treated periodically with mixed stock vaccines containing streptococci prevalent at that time. In our own work most encouraging results have been obtained from the careful isolation of a culture from the suspected sinus, and the preparation of a vaccine according to the technique advocated by Wherry.[14] In all of our cases this treatment has been combined with surgery and a most careful follow-up care of the patient. This latter subject is to be discussed under the head of surgical treatment.

Other workers have reported little, if any, encouraging results from the use of bacterial vaccine. This procedure is still a debatable one. At any rate when once vaccine treatment has been started, after the offending organism has been carefully proven by sensitization tests, it is most important that this treatment be continued over a long period of time, and perhaps repeated during the season when our respiratory conditions are most prevalent. The disregard for this last statement, I think, has led to the unfavorable results reported from the use of autogenous vaccines.

5. *Local and Surgical Treatment of the Nose and Sinuses in Allergic Disease.* The local treatment of the nasal mucous membranes during an acute nasal reaction gives only temporary relief, and is confined to the use of drugs, such as epinephrine, ephedrine, and cocaine. The application of cocaine to the nasal ganglia, as advocated by the late Dr. Sluder, is often effective in certain types of cases.

The operative treatment of the nose and sinuses should call for the closest co-operation between the rhinologist and pediatrician. I wish here to emphasize that it is a duty of both the rhinologist and pediatrician not only to properly diagnose and properly operate these cases, but to continue observations and local treatment over long periods of time, if beneficial results are to be obtained. Too often nasal pathology is corrected, such as removal of septal spurs, submucous resection, operative procedures on the antrum and other sinuses, and the patient discharged thinking that the treatment ends at this point. Our most encouraging results have been obtained when proper diagnosis has been made, necessary surgical procedures performed, and most careful follow-up care given to the patient. The strictest attention must be given by the pediatrician as to the future care of the child. A most rigid routine must be instituted, which includes careful supervision of play, avoidance of exposure to other infections, diet, and general building up of the body resistance of the patient. This often includes change of climatic and environmental conditions. Too often failures are obtained by trying to effect cure by climatic changes only. While the home conditions of the patient may be ideal, many of the parents unconsciously do not co-operate to the fullest extent. Along with this outline it is equally important on the part of the pediatrician to see that any local improvement obtained by operative procedures is continued. This often entails bi-weekly or weekly visits to the office of the rhinologist, in order that he observe and continue to aid in keeping the pathological conditions of the nose in the best possible condition. Operative treatment of the nose and sinuses should not be instituted during acute attacks, such as occur in hay fever and asthma. Operative procedures in the nose, as the removal of septal spurs, submucous resection, and cauterization of the turbinate, may be employed to restore nasal breathing and proper ventilation. Skillern advocates removal of the middle turbinate, even when the ethmoid cells are exenterated. Certain rhinologists (F. Smith))[17] state that complete removal of all the infection of the nose would completely cure seventy or eighty per cent of the cases.

Smith further modifies this statement by saying that complete removal of infection is not always possible in a certain percentage of cases because of the involved and related anatomy. This reference is inserted to show the great variation as to surgical procedures that are advocated. It therefore becomes the duty of the pediatrician to advise when surgical procedure should be instigated, and to what extent completed.

A great deal has been written as to the effects of removal of polypi. It is a general opinion that in most cases these should be removed. Because of the marked tendency of polypi to reoccur Lyons[15] in 1922 advocated the use of radium in the treatment of nasal polypi.

The surgical treatment of sinuses in allergy is confined in the majority of cases to the maxillary antrums and the ethmoids. The ethmoids usually clear up with the use of radium as described. The treatment of the maxillary antrum is perhaps the most important in the management of the sinuses. The occurrence of marked edema, polypi, thickened secretion, and secondary infection in the antrum, usually calls for surgical interference. It is often necessary to open and inspect the interior of the antrum to determine the actual pathological conditions present. Frequently, as outlined above, nasal examinations, x-rays, and diagnostic puncture will give fairly accurate information as to the existing pathology. By means of the simple naso-antral window, it is possible to inspect the antrum by direct vision. Potter,[16] of Buffalo, has advocated the direct inspection of the interior of the entrum by the use of the antroscope. I have had no experience in this procedure. Certain cases, however, may be treated properly by the use of radical operation.

The frontal sinus is not frequently involved in sufficient degree to warrant operative procedure. Secondary infection or extensive edema and polypi may be relieved, however, only by surgical measures.

None can deny that the removal of certain pathological tissues in the nose and sinuses in allergy is not in accord with sound principles of treatment. Gratifying results have been reported, yet as a general opinion most observers believe that the removal of pathologic tissues from the nose and sinuses in allergy has not influenced the allergic state of the individual. The combination, however, of surgical treatment and treatment for allergy has given most satisfactory results.

6. *Non-Specific Therapy.* Many workers have reported good results with the use of tuberculine, peptone, or stock vaccine, in the treatment of these cases. We have seen no particular results in the use of these substances.

7. *Physical Agents.* Marked benefits to the patient have been reported by the use of the ultraviolet light, sunlight, etc. These in our hands have only proven to be adjuncts to the general treatment used in the building-up of the patient's general condition.

8. *Diet.* Definite studies on the pH of the blood have been reported. Jarvis[4] and others have reported excellent results by observing the relation of the acid and alkalin-forming foods, and their curative effect in these cases. Dr. Dean, in his recent address to the Indianapolis Otolaryngological Society, reported some unpublished experiments on animals, which may indicate that alkalinization could be overdone. However, enough beneficial results have been reported from the use of this diet, to warrant its usage in the general dietary treatment of these patients. Alkalies and lemon juice are given with this diet.

Alkali Producing Foods per 100 Gms. cc Base

Almonds; apples; asparagus; bananas; beans, dried; beans, lima, dried; beans, lima, fresh; beans, string, fresh; cabbage; carrots; cauliflower, celery; cherry juice; chestnuts; cocoanuts; cucumbers; currants, dried; dates; figs; grape juice; lemons; lettuce; milk, cow's; molasses; mushrooms; muskmelon; onions; oranges; parsnips; peaches; pears; peas, dried; peas, fresh; pineapple, fresh; potatoes; radishes; raisins; raspberry juice; rutabagas; tomatoes; turnips.

Acid Producing Foods per 100 Gms. cc Acid

Bacon; barley, pearl; beef, ribs, lean; bread, whole wheat; bread, white; cheese, cheddar; chicken; corn, sweet, dried; corn, green; crackers, soda; cranberries; eel; eggs; eggs, white; eggs, yolk; fish, haddock; fish, halibut; fish, pike; ham, smoked; lentiles; meat, beef, lean; meat, mutton, leg; meat, pork; meat, rabbit; meat, veal; meat, venison; oatmeal; peanuts; rice; salmon, canned; sardines; shredded wheat; trout, salmon; walnuts; wheat, entire; wheat, flour.

Neutral Foods

Butter; cream; lard; cornstarch; cane sugar; tapioca.

Summary

It must be recognized that any results obtained in the treatment of chronic sinus disease or allergic conditions of the nose and throat, depend upon the etiologic factor involved. Satisfactory results are entirely dependent upon its treatment and control. It is certain that if allergy can be controlled or possibly cured in early cases, advanced pathological changes may be prevented, and the possibility of secondary infection consequently should surely be less probable. It should be emphasized that if we consider all sinus cases as being either allergic with or without secondary infection, or as primarily infected or suppurative, we should profit by the distinction. By following the principles of treatment adaptable to each group, we should be able to obtain far more satisfactory results than those obtained in the past. This again can only be accomplished by the pains-

taking study of the pediatrician and the most competent co-operation of the rhinologist.

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DISCUSSION

R. H. M. BAYLEY, M. D., Lafayette: My interest in nose and throat disease is in the allergic conditions. In the first place, a person who is in position to have allergic problems put up to him is likely to be "on the spot" innocently at times, and I believe he must have some way of protecting himself. The reason is that any one of your friends may decide that he has an allergic case, and sends it to you with more or less promise to the patient that all his troubles will be over. You spend a good deal of time attempting to find some allergic condition, and wind up in failure. I believe the doctor who is going to refer patients for allergic diagnosis should at least leave a loophole, so that the patient may have a chance to talk it over with the one who is making the diagnosis.

Personally, I believe that going through a long routine of allergic diagnosis without good reason is not only foolish but poor business, because it produces a bad reputation. If a person has had eczema as a child the chances are he has some allergic condition. If he has been subject to rounds of hives, and had severe gastrointestinal upsets associated with some particular food, that increases the chances. If there are other allergic conditions in the family such as asthma, hay fever, sick headaches, possibly epilepsy, or any kind of chronic skin trouble, it increases the chances greatly. If the patient has an eosinophilia it gives you a great deal of confidence that you have some chance of finding an allergic substance.

With that in mind, the method of determining the substance to which they are sensitive is to be considered. Commercial extracts are put on the market and may be bought rather cheaply. Some of the original ones, aside from the pollens, were powders that had to be dissolved in water before using them on the skin—in water or salt solution or weak alkaline solution. Then there are some in which the extract is incorporated in some sort of base. On the other hand, the newer methods are much better. The most recent one is the contact method, in which the skin is vigorously scrubbed, and a piece of cloth or some material, impregnated with the protein you are testing, placed on the skin for, sometimes, only a few minutes. I think that is no great advantage, because it takes a long time to test a person with many substances; but the claimed advantage that it reduces the chances of a person becoming sensitized to another substance is not valid. In order to determine whether or not a person is sensitive to any protein it must get under the epidermis in some way. Whether it is absorbed in one way or another makes no difference. I believe the method of choice is the intradermal injection. The difficulty is that you cannot buy these solutions, so far as foods and such things are concerned. It is necessary for one to make them himself. That is a disadvantage, but on the other hand there are some distinct advantages. In the first place, if a person has an idea that he is sensitive to some substance you will not please him unless you try it; and he may be right; he may be sensitive to some substance of which you have not thought; or it may be something that is not possible for somebody else to discover. Under those circumstances one obtains the substance, makes an extract and tests as with any of the stock solutions. These solutions are not difficult to make. The protein can be extracted in salt solution and sterilized through a Berkfeld filter. Of course, making a lot of them is a big job, but probably in only a few cases do these solutions lose their strength.

As to the reaction which occurs upon the injection of protein, or when the scratch method is used by the application of powders, the reaction is a wheal which occurs within fifteen or twenty minutes after the application to the scratch. The scratch itself does produce a very slight swelling, but it spreads irregularly if the person is sensitive to that particular substance. With the injection method, ordinarily the wheal is less than a half centimetre in diameter. If it increases two or three times in size and we have pseudopod projections, that person is unquestionably sensitive to that substance.

The testing for sensitiveness to bacteria, on the other hand, is different. In the first place, you are less likely to have a wheal from bacterial vaccines, but the reaction is more likely to be a twenty-four

hour reaction. I would like to know if some of the rest of you have found that to be true—that the swelling and redness may extend for four or five inches around the point of inject at the end of twenty-four hours, whereas in fifteen or twenty minutes there is practically no reaction.

Regarding the vaccine treatment of asthma, there is one type of asthma that I tackle with a great deal of assurance, and that is in the case of the person who has had some acute respiratory infection followed by chronic bronchitis, followed by asthma. An autogenous vaccine made from the sputum of such a person and injected weekly over six to nine months will produce a higher percentage of relief, at least until they get the next chronic infection, than anything I know.

H. M. BANKS, M. D., Indianapolis: Two factors in vaccine therapy are frequently overlooked: when to use the vaccine; and how to use it. If anyone hopes to get results—and these remarks are based upon five years' experience with asthma, working with asthmatic patients with vaccine therapy alone with about eighty per cent results—it must be remembered that the predominating factor is to prepare your patient for vaccine treatment. If you think you can get one vaccine that will cure your patient of asthma you are mistaken. The patient must be prepared: First, the internist for general study; and, next, the laryngologist, and this specialist is a most important factor; the patient must be prepared to be sure that all the sinuses are drained and that all foci of infection are open. Vaccine therapy in cases not seen by the otolaryngologist, with the foci of infection plugged up is futile. One might as well not give vaccine therapy. We believe only on that basis can the value of vaccine therapy be determined.

As to the use of vaccine, the way we are inclined to use it is ridiculous. We give the vaccine, send the patient home and tell him to come back in a week or ten days, and expect to get desired results. The patient should be tested carefully, not a thing left out, and all the information charted. Some people use vaccine and expect a result over night, and if they do not get a result in a week or ten days they say the vaccine has failed.

There is another factor that is overlooked frequently in vaccine therapy, and that is the parallelism between immunologic therapy and allergic therapy. The dosages for these two are entirely different, and the results you get in allergy therapy cannot be obtained by giving the vaccine which will give you an immunologic result. Often we find in the allergies that there is superimposed a secondary infection upon the basic cause of the asthma. So far as we have been able to determine, and we have made many tests on people who have asthma and hay fever superimposed upon so-called food allergies, we are more or less inclined to believe that with careful detailed study of the flora of all the tracts we can usually find in the tracts associated with the nose and throat different strains of the same types of organism which will produce reactions of different degrees, similar to the main clinical entity. It is interesting to see the parallelism between food allergy and foci of infection clear up as the patient becomes sensitized. We believe not in autogenous vaccine, not stock vaccine, not general protein therapy, but the specific organism which, when you isolate it in pure cultural methods, will intradermally not only produce a wheal, but systematically produce an exacerbation of cardinal symptoms, and the final test of your vaccine means one that will not only produce a wheal in twenty minutes, but a vaccine that, when you introduce it intradermally, causes, inside of 24 hours, an exacerbation of the clinical symptoms which trouble the patient. You may take exception to that, but we base that premise on eighty per cent of cases in which we get these results.

C. N. HOWARD, M. D., Warsaw: I have a question to ask of the essayist. Here is the case of a young boy having an allergic condition of the nose, and careful questioning develops the fact that it is manifested only after he milks the cows. If we keep him away from the cows and treat him he gets along very well. What practical steps should be taken, after having determined that the allergen comes from the cow, in order to desensitize this patient?

H. B. METTEL, M. D. (closing): In answer to Dr. Howard's question, I would say that quicker and better results could be obtained by preventing the boy from coming in contact with the cows. I have a similar case in a boy with asthma who is sensitive to horse dander. His father and mother are the owners of several saddle horses and the boy desired to continue riding. In such cases an extract of horse dander is made up in dilutions of from 1-100,000 to 1-100. The boy is then given intradermal skin tests to determine his reaction to these solutions. I usually begin desensitizing with the solution below that which gives a positive reaction. With this determined one can continue desensitization in any manner he chooses.

I wish to lay stress on the importance of giving the vaccine over long periods of time and at frequent intervals. You can use a stock vaccine if the vaccine is tested to see if the patient gives a reaction. If you fail to obtain a reaction I believe a stock vaccine will be of little value as a therapeutic measure.

THE ASSOCIATED PSYCHONEUROSIS*

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Mrs. B., 56, farmer's wife. A married sister, who was very near the patient, died unexpectedly four years ago. A few months later the younger of the patient's two sons died an accidental death. The older son was married and somewhat estranged. The patient began to complain of pain in her back and of sleeplessness. The family doctor directed her to a laryngologist and tonsils were removed. Symptoms persisted. Her remaining teeth were condemned and removed. Plates were unsatisfactory and she experienced no improvement in her symptoms. She was next sent to a gynecologist, who amputated her cervix and promised hysterectomy if no relief was obtained from the amputation. The patient's well-developed psychoneurosis grew very definitely worse during the four years of medical supervision.

The foregoing few outstanding features are taken from the history of a patient referred in 1924. That it was necessary to go so far back in histories before finding a suitable one is a very pointed compliment to the profession and evidences a forward step in the handling of this class of patients. It is no longer common for a specialist to justify an operation by merely proving the existence of pathology in his field. He is now feeling a responsibility which makes necessary the establishment of the probability that the symptoms manifested by the patient are going to be favorably influenced by the procedure he is recommending. It is becoming a very frequently repeated experience to have the specialist report that he finds some abnormality revealed by his examination, and then state it as his opinion that the symptoms complained of are not likely to be removed by correcting the condition noted. So impressive is the progress in handling this type of associated psychoneurosis that I take this method of removing it from our consideration at this time. There is, however, a closely related field which is by no means so well cared for.

Mrs. C., 34, wife of a factory foreman, in barely comfortable circumstances, mother of five children, developed a persistent pyuria without other important symptoms. The patient was referred for urologic study. A strictured right ureter was treated for about ten days, during which time the patient remained in the hospital. For a time after leaving the hospital the patient returned, at intervals, to the urologist for treatments. The urinary infection cleared up promptly, but in the meantime a very definite and troublesome psychoneurosis developed.

Mr. R., 52, retired from a wholesale business. While visiting in a distant city he was induced to have a health survey by the relatives' own splendid physician. In spite of the fact that the patient was symptom-free, stress was laid on the insistence that no pains be spared in a most thorough search for any abnormality. In the course of the examination an x-ray plate of the spine was made and some lipping of certain vertebrae was pointed out to the patient. It was then recalled that a similar finding was reported while in a sanitarium twelve years earlier. No other finding of importance was made. A few days after the examination was completed the patient's back became stiff and pain on motion was complained of. The visit was extended for some days, with the hope that improvement would enable the patient to drive his car back to his home, but the symptoms grew worse and he was scarcely able to make the return trip with others attending him. It was a few months before all disability resulting from the psychoneurosis was removed.

Mr. D., 34, married 12 years; factory worker; wife and three children in good health; had never suffered any serious injury or illness. The patient was placed at work operating a machine which shook him violently during certain manipulations, and this operation had to be repeated every few minutes. The two preceding operators of this particular machine had been unable to continue work with it but a short time. At the end of four days the patient noted numbness in the fingers of the hand on the contact side and was sent to the company's doctor. A few days later a marked loss of power was noted in the muscles of the entire left side. There was undoubtedly peripheral nerve injury explaining some of the early symptoms, but the most disabling features were occasioned by the accompanying psychoneurosis which developed while the patient was under medical treatment.

Such histories as the last three briefly sketched are relatively common and it seems that their number is increasing. There is one common present-day practice which helps in some instances to set the stage for these pathetic farces. In this I refer to the inclination of patients to consult specialists on their own initiative, and, in so doing, to break liaison with those best qualified to avert disasters of the kind under consideration. Several times each year the writer is informed, sometimes by telephone, that a patient whom he has never seen has just returned from a certain specialist or clinic, and that while there he gave the name of the writer as his family physician. When asked why the name of his actual family physician was not given, the reply is usually that he does not have one or that he fears his family physician would not understand his having consulted another without his knowledge. We would probably all agree that the potentially psychoneurotic is the patient most likely to be found in this situation, but specialism has been so oversold to the laity that we find many without obvious mental bias doing just the thing described.

The young married woman with the pyelitis,

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never in a hospital before, even for the delivery of any of her five children, was not very sick and readily gave permission for the three chummy nurses to visit during the evening in her room. The nurses' shop-talk of the child dying in the adjacent room from injuries received in a street accident did not diminish the anxiety of the mother for her family back home in the care of others. This setting, added to the suffering necessarily entailed in treatment, was not entirely offset by the splendid progress the infected kidney made. The spinal pathology of the retired business man was symptomless until revealed in the impressive manner of the x-ray plate. The factory worker was emotionally unprepared for the various diagnostic measures of the diligent medical men.

The chief factors disturbing the emotional adjustment in each of the three patients mentioned varied somewhat, but still we find many things in common. There was nothing in the condition of any one of them which would indicate a strong tendency to psychoneurotic disturbances. Medical contacts had been so few that the more modern details of examination and treatment were new and impressive. The handling of the patients created in each instance an anxiety state wholly new and unexpected. No adequate offsets to the trends of thought produced were established.

Our problem is thus revealed to be one of realizing that psychic trauma may result from some of our very common diagnostic and therapeutic measures; that we are at times misled in our judgment of the degree of emotional stability of our patients; and that we attempt the early detection of the trend toward the anxiety states and apply the necessary corrective measures. Unless our work is such as to make us constantly conscious of the fact, we need frequently to remind ourselves that the object of the exercise of mental function is adjustment to environment. If we are dealing with a patient who is in satisfactory adjustment, and seek to avoid disturbing this adjustment, it is logical that we impose the fewest possible alterations in his accustomed situations; and when it is necessary to introduce something entirely new we should make it as unimpressive as possible and try to fit it into the patient's thinking if the measure seems at all disturbing.

As a further means of avoiding the development of a psychoneurosis in the course of our practices, the patient's history is a matter of great importance. The man doing work in a restricted field of medicine is prone to elicit only those points of history which have a direct bearing on his work. Unless this limited history is supplemented by that of a medical man thoroughly conversant with conditions, the patient's situation is not adequately safeguarded. The history pertinent in such cases should not stop with the inquiry as to whether the patient has suffered any serious nervous disorder. The thing sought is to determine if the emotional balance is equal to the strain about to be imposed upon it. All past experiences of a patient may have been borne without evidence of strain and still not have been such as to develop resistance to the experiences about to be introduced. Even in this day of rapid diffusion of general information we observe that medical sophistication is not universal and we still find an occasional patient to whom cystoscopy with ureteral catheterization, as well as some less complicated manipulations, is impressive. With a carefully taken general history before us, the planning of the work contemplated is facilitated. Quite aside from the value of the history on account of the information it supplies to the doctor is the almost certain effect of establishing a confidential relationship well calculated to offset otherwise harassing experiences.

In spite of the preventive measures suggested some patients will be thrown out of adjustment by our necessary procedures; and to such patients we owe our best efforts at early detection of the condition. Often the first evidence we get of the development of an associated psychoneurosis is the failure of symptoms to disappear with improvement in the conditions we are treating. And, if this occurs along with an obvious change in the patient's attitude toward those caring for him, an almost certain diagnosis of beginning psychoneurosis is made. If at this juncture the patient can be returned to his former environment a prompt readjustment may be effected, and to the end that the interrupted procedures be safely resumed. Should this expedient, together with the steadying influence of the family physician, result in failure the condition to be dealt with is that of a fully developed psychoneurosis and deserves the management appropriate in such cases.

Summary. It is not the purpose of this paper to discuss the management of psychoneurosis in its larger aspects. Acknowledgment is made of some progress in the handling of a certain class of associated psychoneurosis. A few facts are then taken from the histories of patients whose emotional balance was disturbed while under medical or surgical care and used to call attention to some commonly overlooked opportunities for obtaining more satisfactory results in the practice of medicine.

THE DIARRHOEAS OF EARLY LIFE

A Simple Classification and an Outline of Treatment

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Diarrhoea is a frequent symptom in early life, and is a clinical manifestation of the sensitivity and immaturity of the infant's gastrointestinal tract. The nutritional demands of the rapidly growing infant make it necessary for a delicate and vulnerable digestive system to work at all

times close to its functional capacity. This leaves a small margin of safety between functional capacity and nutritional need which is easily obliterated by a variety of disorders. It may be said that infantile diarrhoea is not a disease, but is merely an indication of the alimentary tract's responsiveness to various kinds and degrees of ill health. Impairment or diminution of alimentary secretion not only retards digestion but permits bacterial invasion of the normally sterile upper bowel, either from contaminated food or by migration upward of the organisms ever present in the lower bowel. Partially digested foods and the toxic products of bacterial decomposition produce mechanical and chemical irritation of the intestinal mucosa. In response to these stimuli there is an increase in peristalsis and an outpouring of fluids from the visceral circulation. This attempt to neutralize and wash out the irritants manifests itself at the bedside as diarrhoea.

Season exerts such an important influence on the incidence of diarrhoeal diseases that their occurrence, for the most part, is limited to the hot months of the year. The humid summer heat is a potent factor in reducing the infant's digestive capacities below the limits of safety. Likewise, overheating from too much clothing increases the tendency to diarrhoea.

The importance of diet and hygiene as etiologic factors is emphasized by statistics which show that the vast majority of diarrhoeal diseases occur in artificially-fed infants in unhygienic and overcrowded districts. The incidence of diarrhoea is greater in the artificially fed because of the chances of contamination and the variability of composition of the food. However, an artificially-fed infant with a properly balanced formula and in good surroundings is little, if any, more likely to develop diarrhoea than the breast-fed infant.

Diarrhoea then may occur as the result of simple overheating, poor environment and diet, or it may appear as a part of the symptom complex of a variety of parenteral and enteral infections.

Classification

Diarrhoeas have been classified in many ways and from many standpoints. More recently classification has been relegated to the background and greater emphasis is given to prevention and treatment.

Etiologic, pathologic and clinical overlapping does not allow a clear-cut classification of the diarrhoeas. Nevertheless, as some arbitrary grouping is desirable for the correlation of accumulated data, the following simple classification, which takes cognizance of the "soil as well as the seed," is offered.

I. Functional Diarrhoeas. This group includes the non-contagious diarrhoeas resulting from an overstepping or a depression of the functional capacities of the gastrointestinal tract, whether it be due to improper feeding, environmental factors or parenteral infection. From the standpoint of previous nutritional history this group may be further subdivided:

(a) Diarrhoeas caused by disturbed digestive function in previously well-nourished infants. As a rule diarrhoeas in these infants follow a mild and uneventful course, if treatment is instituted early.

(b) Diarrhoeas caused by disturbed digestive function in malnourished, neglected infants. Diarrhoeas in these infants are apt to be of severe type that require intensive treatment.

II. Infectious Diarrhoeas. Constitute a group with a more or less definite pathologic basis and are considered as true infections of the gastrointestinal mucosa with some specific organism. These diarrhoeas are contagious and may occur in epidemics.

It must be borne in mind that while most diarrhoeas can be pigeon-holed in one or another of the above groups an occasional overlapping takes place. That is, a severe functional diarrhoea can occur in a previously well-cared-for baby and a mild diarrhoea can occur in a malnourished baby. Furthermore, bacterial invasion of the intestinal mucosa may supervene on what started as a functional diarrhoea.

Symptoms

Functional (a) Diarrhoea in Previously Healthy Breast or Bottle-Fed Babies. The nutritionally sound infant, whether breast or artificially fed, whose digestive capacity is overstepped from temporary overfeeding or is depressed from external heat or infection is likely to have a mild form of diarrhoea which responds promptly to a short starvation period and the administration of a proper diet. These cases comprise the so-called dyspepsias. The history will reveal that the diarrhoea is not of sudden onset but is antedated by a period during which there is some regurgitation of sour, thin fluid before the customary feeding time. Possibly there will be transitory seizures of colicky pains. Infants at this stage show no toxemia or dehydration and seldom have fever. Excoriation of the buttocks is the rule, due to the numerous fluid green stools which contain mucus and are acid to litmus paper. If there is little or no excoriation of the buttocks the stools are probably alkaline in reaction.

Functional (b) Diarrhoeas in Infants with Poor Nutritional History. Any lowering of digestive function by parenteral infection, heat or contaminated food in an infant of poor nutritional history and in an unsuitable environment is conducive to a severe and probably a toxic grade of diarrhoea. This group constitutes a large part of the so-called summer diarrhoeas and is seen in the clinic oftener than in private practice. If the frequency of stools continues for days or perhaps a week or two, the depletion of body fluids results in a general disturbance of tissue function. Occasionally there is a prompt and rapid loss of fluids

with acidosis and toxemia. The infant is restless and fretful, sleeps brokenly, cries a great deal, and sucks his hands as if hungry. The face soon becomes drawn and the subcutaneous tissues take on a doughy, inelastic feel. The urine is diminished in quantity. The weight loss depends upon the rapidity of fluid loss. The abdomen may be distended. The stools are very numerous, thin, green, contain mucus, and are usually acid as evidenced by excoriation of the buttocks.

Infectious Diarrhoeas (Dysentery, Ileocolitis, Inflammatory Diarrhoea). In this group, the intestinal mucosa is infected with some specific organism, usually of the colon-dysentery type, but occasionally with the streptococcus or the gas bacillus. Infectious diarrhoeas also occur during the hot summer months because of the special vulnerability of the intestinal tract during this season of the year. They are common in poorly-cared-for infants because of the greater chances of contamination of the food. Infectious diarrhoeas, however, may occur in any infant regardless of previous nutritional history if the gastrointestinal tract is exposed to virulent strains of the above-mentioned organisms. Infection of the digestive tract is occasionally a sequel to one of the functional diarrhoeas. Infectious diarrhoea is often a true epidemic disease and may be spread in the same way that typhoid fever is spread, "fingers, food and flies." As a rule the onset is sudden, with or without vomiting. Aversion to food is a noticeable feature. The pulse rate is rapid and may or may not be associated with high temperature. Evidences of toxemia are present from the onset. Dehydration complicates the toxemia if there is a persistent fluid loss through the vomitus and stools. The stools of infectious diarrhoea are fairly characteristic: they are small, frequent, accompanied by pain and tenesmus, and are apt to be alkaline or neutral in reaction. After the second day they contain mucous, blood and pus.

Treatment

Starvation Period. A short period (12 to 24 hours) of physiologic rest during which all digestive effort is suspended is advisable if the diarrhoea, regardless of type, is seen early. Fluids, in the form of barley water or weak tea sweetened with saccharine, should be given by mouth during the starvation period.

Cathartic. The administration of a cathartic depends upon the feeding history and the views of the attending physician. A cathartic as a rule is not given unless the infant is seen early in the course of the diarrhoea. Some feel that the preliminary starvation permits the prompt emptying of the intestinal contents because of the auto irrigation of the digestive tract by means of the profuse outflow of fluids from the blood stream into the intestines. Cathartics would appear to aggravate still further an already irritated condition of the alimentary tract. Milder functional diarrhoeas respond promptly to the mere withdrawal of food and the forcing of fluids by mouth for a short period of 12 to 24 hours.

Drugs. Play a very small part in the treatment of infantile diarrhoeas. The large number of drugs used is an indication of their lack of value. Frequently they prove to be not only useless but actually harmful and may divert attention from more important therapeutic measures.

Bismuth is widely used, but some authorities brand it as practically valueless.[1] If given it should be used in the subacute stages in doses of 15 to 40 grains of the subcarbonate every 3 or 4 hours.

The use of opium has been vigorously opposed and indeed it should be, unless definite indications for its use are presented. It should not be used in the acute stages, especially where there is abdominal distention, but in the subacute stages is sometimes valuable in resting an overirritated nervous system.

When abdominal pain complicates diarrhoea, atropine is a drug of great usefulness. 1/1000 to 1/800 grain hypodermically or by mouth (in a 15 pound infant) often checks abdominal pain and tenesmus.

Water and Mineral Balance. Prevention of dehydration or adjustment and maintenance of water and mineral balance is the sheet anchor of treatment in all forms of diarrhoea. Fluids by mouth suffice when there is no manifest dehydration. In cases in which frequent and profuse evacuations produce dehydration and acidosis, fluids must be provided subcutaneously, intraperitoneally or intravenously. With careful technique 100 to 300 cc. of Ringer's solution, Hartman's solution or normal salt solution can be given intraperitoneally at 8 to 12 hour intervals until dehydration is overcome. This is an advantage over the subcutaneous method because it is less painful and produces less shock.

The continuous intravenous infusion of fluids has recently obtained much deserved popularity as a method of giving parenteral fluids. This usually necessitates dissecting out one of the superficial veins, which is not a formidable procedure and is well worth the slight extra effort. The administration of fluids in this manner does not flood the system with salt and glucose solutions periodically and allows for a steadier readjustment of all physiologic processes. J. M. Brush[2] reports an ingenious device for the continuous administration of fluids which offers distinct advantages over other methods.

Blood Transfusions. Poole & Cooley[3] feel that transfusions often overload an already concentrated blood with cells and blood proteins, whereas the administration of 5% glucose in saline will not only dilute the electrolytes and blood proteins but also mitigate the toxemia. When the concentration of blood is reduced, dramatic clinical improvement is manifest by cessation of vomiting, a drop in temper-

ature and disappearance of other evidences of toxemia.

During this critical period the infant's chief requirement is water and in order to obtain satisfactory results each patient must be individualized. Blood transfusions are among the most valuable of the therapeutic procedures but their indiscriminate use is unjustified. The authors[3] outline some relatively simple laboratory tests which, when taken with the clinical findings, rationalize the use of blood transfusions in these extremely sick infants.

Some authorities[4] advocate the prompt administration of polyvalent antidysentery serum in infectious diarrhoeas (due to the dysentery bacillus) in amounts totalling 200 cc. to be given in divided doses of 50 cc. each every 5 or 6 hours. It is well to give the serum intravenously diluted with glucose or saline. The use of anti-dysentery serum combats the toxemia or bacteremia. Transfusions of human blood may be preferable to the antidysentery serums for the purpose of increasing the immunity to the offending organism.

DIET. *Breast-fed* infants with diarrhoea should be treated to a short starvation period, then should have 1 to 1½ ounces of the following mixture *before* each breast feeding:

Casec	5 packed level tablespoonfuls
Water	10 ounces
Saccharine	¼ grain

Dietary treatment in the *artificially-fed* infant depends upon the type of diarrhoea. Much valuable time is saved and perhaps injury to the patient avoided if the character of the stool is taken into consideration before the diet is prescribed.

A large number of the functional diarrhoeas are characterized by acid, excoriating stools and require a relatively high protein diet from the beginning. The non-acid skimmed milk, Casec mixtures for many years have been an effective weapon in the treatment of this group. Three to five ounces of the following mixture may be offered every three or four hours after the starvation period:

Skimmed milk	10 ounces
Casec	8 packed level tablespoonfuls
Water	20 ounces
Saccharine	1 grain

Carbohydrates must be added to this diet after a day or two, starting with about two level tablespoonfuls of Dextri-Maltose and increasing cautiously (but within a few days to a week, if possible) to six level tablespoonfuls. Transition to a formula of normal proportions and adequate caloric value should be a gradual process after subsidence of diarrhoeal symptoms. Return to normal diet may be accomplished in a few days in the diarrhoeas of those with good nutritional history, whereas the return must be more deliberate in the poorly nourished.

There is a group of diarrhoeas characterized by the so-called proteolytic stool, which is brown, watery, stinking with putrefactive odors, non-excoriating and usually alkaline in reaction. Treatment is said to be more rational if the proteolytic organisms are discouraged by the feeding of a temporary carbohydrate diet in the form of a thin cereal gruel for the first day or two following the starvation period. Three to six ounces of the following may be given every three or four hours:

Wheat Flour	8 level tablespoonfuls
Water	30 ounces

Cook in a double boiler for an hour; strain and add a pinch of salt and one grain of saccharine to increase the palatability. Corn starch, arrowroot or rye flour may be used instead of wheat flour if preferred.

When the stools become less foul and more solid one of the formulas listed below may be substituted (three to six ounces every three or four hours).

Powdered Protein Milk or Powdered Lactic Acid Milk	12	level tablespoonfuls
Dextri-Maltose	6	level tablespoonfuls
Water	30	ounces

If the powdered milks are not available, buttermilk or skimmed sweet milk 24 ounces, Dextri-Maltose 6 level tablespoonfuls, water 6 ounces, may be used.

Return to a formula of normal proportions must be accomplished as soon as the infant's general condition permits.

The above outlined dietary procedure (e. g., carbohydrate diet for a few days followed by an acid or skim milk formula) is most efficacious in the treatment of the *infectious diarrhoeas.*

For those who prefer acid milk mixtures for routine treatment, regardless of the character of the stools, a choice is offered of one of the following formulas as a starting diet:

Powdered protein milk or powdered lactic acid milk, 12 level tablespoonfuls; water, 30 ounces; three to six ounces to be offered every three or four hours.

Buttermilk, 24 ounces; water, 6 ounces; three to six ounces to be offered every three or four hours.

Carbohydrate must be added in a day or two, starting with two level tablespoonfuls of Dextri-Maltose to the day's formula and increasing to six or eight level tablespoonfuls as rapidly as the infant's clinical course permits. A change to a formula which will fulfill the requirements for growth and nutrition should be made as soon as convalescence is established.

SUMMARY

The fundamental principles to be kept in mind for proper diagnosis and rational treatment of diarrhoeas may be summarized as follows:

1. An accurate history with special attention to the infant's previous diet and state of nutrition.
2. A thorough search for parenteral as well as

enteral infection and careful physical examinations to determine the degree of dehydration and toxemia.

3. Treatment directed toward resting the gastrointestinal tract for a short period, provision of food adapted to a limited digestive capacity, restoration and maintenance of fluid and mineral balance, and the judicious use of blood transfusions.

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MALIGNANT NEUTROPENIA

Case Report

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Schilling has suggested the term "malignant neutropenia," which has been variously described by different men as malignant neutropenia, agranulocytosis, leukopenia, granulopenia, or granulocytosis angina. The symptom complex is characterized by peculiar, ulcerative, necrotic or gangrenous lesions of the mouth and throat, with a lowered white count and almost complete loss of polymorphonuclears from the blood, and in most cases a rapidly fatal result. It may be that this is a clinical entity, but it may also be that it is an atypical form of sepsis. It may occur in either sex and in any age, but in a series of eighty-two cases, seventy-five were in females.

The progress is usually rapid. The prognosis is always grave and the mortality is from eighty-five per cent to ninety per cent. None of Schultz's original series was cyclic. Goldenberg reports a case of granulopenia with death from a third attack.

The past history of my patient is irrelevant, except that for the past twenty years she has had a complete alopecia. She was a highly nervous person, but beyond an occasional mild illness, such as an upper respiratory, she has had no infections. She had an appendectomy about ten years ago; two children, no miscarriages; married twice. There was no history of typhoid, malaria, gonorrhea, tuberculosis, lues or any other infectious disease.

Case report. Mrs. K., white, age 49, was taken ill February 26, 1932, with a chill, elevation of temperature and left ethmoiditis. I saw her for the first time on March 8th, when I found her with a white count of 1,600; polymorphonuclears, 45.5 per cent; lymphocytes, 50.5 per cent; large mononuclears, 3 per cent; irritation leucocytes, 1 per cent. She was immediately taken to the hospital, where she was given a transfusion of whole blood by Dr. Gatch. Nucleotide was given twice daily for five days and then daily for another week. Her reactions were very severe, but there was apparently no change in her blood count. Various nonspecific proteins were given without effect.

Her physical examination showed ethmoid sinusitis; two teeth with pyorrhea; other sinuses and throat, negative; ocular reflexes, normal; lungs, normal; abdomen, negative; pelvis, normal; rectum, normal; reflexes, normal. She did not seem to be an especially sick woman. Her temperature ran along with a daily elevation, sometimes as high as 102.5, but mostly 100 in the afternoon, and subnormal in the morning. The urine was examined daily and was negative on all examinations. Blood cultures were taken on alternate days and were negative except one, taken on April 12th, which showed a staphylococcus aureus, but this was thought to be a contamination. Wassermann, negative; agglutination for typhoid fever and undulant fever, negative. Cultures from the sinuses were negative until the 23rd of April when the nasal culture showed a streptococcus viridans. The spleen showed no enlargement before the 11th of April, and then it gradually enlarged until it reached three fingers' breadth below the costal margin. On April 10th her general condition became worse and she developed an erythema nodosum with general aching, and it was at this time that x-ray treatment was begun. Her elevation of temperature had been constant, and her white count, which was taken daily, showed no special change. X-ray was given over the long bones and the spleen for a course of two and a half rounds. Her temperature dropped immediately to normal and was practically normal from April 17th until her dismissal on May 11th. Her blood picture never at any time showed any change in the red or the hemoglobin which was practically constant, 4,600,000, with a hemoglobin of 97. Her lymphocytes ranged from 24 to 56. Myelocytes were seen on several occasions. There was a loss of weight from the time of the beginning of her illness in February until she left the hospital on May 11th, of about twenty pounds. Her last blood count on May 11th showed hemoglobin, 85; red blood cells, 4,400,000; white cells, 3,500; polys, 62; lymphocytes, 24; monocytes, 4; metamyelocytes, 2; band cells, 8. Wassermann, complement fixation for tuberculosis and gonococcus, negative. Malaria and typhoid fever, negative.

During the summer, spent in northern Michigan, she was in good condition and went out socially. About September 10th she had a slight elevation of temperature and diarrhea, and she went into the hospital because she feared typhoid, there having been some typhoid in the community. Her white count was found to be 2,700, and the doctors there sent her home. I saw her on September 19th. She had no elevation of temperature; her spleen was not palpable. Her blood count was, hemoglobin, 88 per cent; red cells, 4,600,000; leucocytes, 1,750; lymphocytes, 36 per cent; myelo-

cytes, 61 per cent; myeloblasts, 3 per cent; and a complete absence of polys. It was decided, in consultation, that as long as her sinuses seemed to be the root of her infection, it would be best to take her to Tucson, Arizona, and that she could get her x-ray treatment there as well as anywhere. She walked to the train, and was all right until Tuesday, September 20th, when she had a chill, and an elevation of temperature to 103.5, which was practically constant through the night. She had terrific pain in the right frontal sinus and throat and her mucous membranes were very red, with a free, watery discharge. Blood pressure was 110/70. Elimination was good from her bowels and bladder. Vomiting began Wednesday noon. She was taken from the train in a semi-conscious condition and taken to the Desert Sanatorium. Her pulse was slightly irregular. A total white count of 50 was made, with a complete absence of polys. Terminal pneumonia developed from which she died after a three days' illness. An autopsy was performed.

Autopsy[1]

Pathological Diagnosis: Coalescing broncho-pneumonia of right upper lobe with beginning extension to middle lobe.

A. External Examination

General: Build, modified pyknik, apparent age 45; general nutrition, good; head, bald; anomalies, none; signs of trauma, none; surgical wounds, none; scars, none; skin, fair; mucous membranes, no hemorrhages, no ulceration; muscles, usual development; rigor mortis, none; panniculus, ten cm. double thickness; edema, none; hypostasis, usual; putrefaction, none; orifices, negative.

B. Internal Examination

Spinal cord, not examined; head, not examined.

Thorax: Left lung, dorsal hypostasis; right lung, entire upper lobe involved in the red hepatization of coalescing broncho-pneumonia. Early extension to a small layer of the upper portion of the middle lobe. Bronchi: Streaked by fibrino-sanguino purulent exudate. Scanty. Near hilus in right middle lobe there is a healed, pea-sized, partially calcified nodule, and old tuberculous focus. The peribronchial nodes are enlarged to small lima bean size and are anthracotic.

Mouth and Neck: Not examined.

Abdomen: Peritoneum, one nodule is found on the peritoneum just anterior to the bifurcation of the abdominal aorta; it is spherical and 3 m. m. in diameter; the outer zone is a translucent jelly and the central spot is a pale yellow; it suggests a possible parasite. Spleen: Boggy spleen of acute infection; entire perisplenic structures are studded with nodules similar to the one described above; 200 to 250 are present; few similar nodules found in spleen pulp. Large intestine, normal. Appendix, normal. Small intestine, no pathology. Duodenum, no pathology. Bile passages, patent and normal. Stomach, the mucosa and musculature are normal but are separated by a pale greenish gelatinous tissue approximately eight millimeters in thickness and fairly even over the whole stomach wall; the organ feels like a heavy, soggy, thick-walled sac; on cut section, the tissue separating the gastric mucosa from the muscularis is seen to be supported in a travecular net by a fibrous mesh. Pancreas, normal. Liver, normal with exception of few yellow-white nodules similar to those found in the spleen pulp. Gall bladder, normal; no concretions. Portal vein, normal. Mesenteric lymph-nodes, small, pale, 2x2x4 m. m. Left adrenal, normal. Left kidney and ureter, normal. Right adrenal, normal; autolysis more marked than on left. Right kidney and ureter, normal. Abdominal aorta, normal. Iliacs, normal. Ascending verna cava, normal. Retroperitoneal lymphnodes, similar to mesenteric nodes described above.

Female Pelvis

Rectum, normal. Vulva, normal. Bladder, trigonenormal. Vagina, normal. Cervix, normal. Body, normal. Tubes, three very small hydatid cysts of Morgagni on right, 2 m. m. in diameter. Ovaries, early atrophy; approximately three-fourths normal size. Ligaments of uterus, normal.

Special Regional Examination

Marrow, rib marrow bright red and abundant, typical of hyperplasia.

Histologico-Pathological Diagnosis

1. Spleen: The lymphoid follicles are atrophied and do not show any germinal centers. The pulp is very hyperemic and contains scattered areas of hemorrhage. The trabeculæ are thickened. In some parts the splenic capsule is thickened both by fibrous tissue and by epitheloid granulation tissue, very loosely arranged. There are numerous nodular lesions the size of one-half to two low power fields some of which show circular strands of hyalinized connective tissue, and others caseous homogeneous material in the center. Both types of nodes have dense fibrotic capsules, and in and around the capsules some round cell infiltration and a few scattered Langhans's giant cells. In one section of the spleen there is an oval calcified mass half low field diameter which shows a capsule and in the capsule small ovoid bodies with laminated walls.

2. Liver: The cord cells are slightly granular. The sinusoids are slightly dilated. There are a few nodules as described in the spleen. In addition there is seen an occasional small cellular tubercle composed of epitheloid and giant cells, and some fibrosis.

3. Ileum: Normal.

[1] Report from The Desert Sanatorium of Southern Arizona, Inc.

4. Adrenal: Moderate amount of edema, otherwise normal.

5. Gall Bladder: Normal.

6. Cervix: Normal.

7. Kidney: Occasional glomerulus is fibrosed; otherwise normal.

8. Ovary: Multiple corpora albicantia and one serous follicular cyst; otherwise normal.

9. Mesenteric Lymph Node: Most of the normal structure is obscured by loose epitheloid granulation tissue, arranged more or less in small nodes and containing a few typical Langhans's giant cells. Some of the nodes show marked fibrosis.

10. Stomach: The surface of the mucosa shows marked autolytic changes. Between the mucosa and the muscularis, there is a wide zone of loose connective tissue which is separated by massive edema. This zone is up to two low-magnification diameters wide. The muscle fibers of the muscular layer are separated.

11. Tracheobronchial Lymph Node: Has the same appearance as mesenteric lymph node with the addition of a moderate amount of anthracosis.

12. Heart: Normal.

13. Uterus: Normal.

14. Aorta: Slight lipoid deposits in the intima cause moderate disturbances in the arrangement of the elastic fibers. There are a few areas of necrosis in the media around the lipoid deposits and scar tissue; adventitia normal.

15. Jejunum: Normal.

16. Pancreas: Normal.

17. Uterine Tube: The villi are slightly edematous, otherwise normal.

18. Lung: a. There is one large sub-pleural completely caseated focus surrounded by dense highly connective tissue. The surrounding lung tissue shows diffuse fibrosis and some anthracosis.

b. The rest of the lung tissue shows scattered patches of purely serous infiltration of the parenchyma. The exudate is almost completely acellular. There is moderate anthracosis around the bronchi and blood vessels.

19. Bone Marrow: A section through the bony part of a rib shows acellular bone marrow with a fair number of megakaryocytes and nucleated red cells. In addition there are what appears to be myeloblasts, but granulated cells are absent.

In all sections in which blood vessels containing blood are seen, the absence, or a scarcity of white blood cells, is striking.

Conclusions

The pathological and histological findings suggest the following conclusions:

1. The patient had undoubtedly agranulocytosis, as proved by the blood counts during the last period of life, by scarcity of white blood cells in sections, and by the acellular exudate in the lung. The latter lesion, quite extensive as noted in the macroscopic description, is probably the immediate cause of death. This is a typical occurrence in agranulocytosis and it is at the same time the most striking demonstration of the exhaustion of the leukopoietic function. Contrary to the usual findings, a necrotic ulcerative lesion has not been found, although it may have been present in some parts which were not examined. It is possible that the findings in the stomach, extreme edema and some necrosis of the mucosa (interpreted as autolytic changes) represent a very early stage of such necrotising lesions.

2. The patient must have had repeated hematogenous seedings of tubercle bacilli. This is evidenced by the numerous tubercles in the lymph nodes, the spleen and the liver. These tuberculous lesions are evidently of very different ages, indicating repeated seedings. It is likely, however, that these tubercles had no direct relation to the lethal disease.

3. The calcified focus in the spleen may possibly be a calcified parasite, the nature of which could not be determined, but since it is completely encapsulated and calcified, it has evidently no clinical significance.

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PUBLIC OPINION

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We are informed that medical practice is on trial. We are told that rugged individualism is *passe*. Our inalienable right to have unlimited opportunities for developing careers of professional independence in free and dignified competition is being threatened with usurpation. The doctor's capacity to control his own destiny is being questioned. Our freedom to regulate our own affairs and our share in all legislation relating to the public weal are menaced with unjust restriction. How will we meet the challenge? What shall be our plan of battle?

From whatever point of vantage a start may be made, in the last and final analysis, when the clouds roll by and the peal of thunder and the flash of lightning clear the atmosphere, it will be found that the doctor's strongest support and stanchest ally is, and will continue to be, an enlightened public opinion. Toward the end of winning and holding this support, and with the view of moulding this opinion, armed with the righteousness of our cause, spurred onward by the knowledge that the public weal ever has been our altruistic aim, let every Indiana doctor step militantly and valiantly forth, dedicating his every

effort to holding high the torch of professional ethics and idealism.

First, however, let us organize our forces, make a survey of our possibilities, and, by reading the lessons of the past, determine the future probabilities. In the front line, the spear head of our attack, capable of withstanding the most brutal assault, will be our men of experience, men who have been out in active, competitive practice for a considerable number of years. They may be battle-scarred, but they are veterans of many a good fight. They have won and lost; but, in losing, they have learned tactics of inestimable value. They have made contacts with the public, many perhaps unattainable by the neophyte. They are, or should be, well-grounded in the principles and ideals of competitive medical practice. They must know strategy; they must be schooled in diplomacy and capable of feeling the public pulse; they must have the hand of steel smoothly gloved in soft kid. Back of these men stand the active reserves from whom much help and assistance should be expected. These are men who have been in practice for perhaps a medium period or longer; they have had their professional eye teeth cut; they are or are being established in the community in which they live. These men must be understudies of the veterans. The older men must confide in them and look to them for vigorous help. They must be taught to assume responsibilities; they must be given work to do. Then come the recruits, the recent graduates and those with but a few years of experience. Their footsteps must be guided into the proper paths of medical organization; they must know what it means and what it proposes to accomplish. These men are replacements for the troops just ahead. No man lives by himself alone and our efforts must be unified to the n-th degree, for indeed the way we are practicing medicine today is a direct result of the achievements in medical organization accomplished by men who have gone before us. These new recruits within our ranks must be shown that the way that they will practice medicine in their middle and old age is absolutely and directly dependent upon what they do right now, today, in the way of medical organization. The help that they give and the effort that they put forth toward the perfecting of medical practice during their own professional youth and adolescence is the yardstick by which they can measure their opportunities during their own maturity. Neglect the one; the other, necessarily, will suffer. The younger men are the captains of their own destiny.

Above everything else, every single individual Indiana doctor should be well grounded in the principles and policies of medicine. He must know that medicine is the trustee of society and that the public weal is our first consideration. He must realize that public opinion, in the long run, will mould and temper our professional attainment. He must accept competitive medical practice with dignified idealism and not with selfish commercialism. He must be confirmed in the righteousness of the personal relation between the individual patient and the individual doctor. He must be cognizant of his own privileges and individual capacities. He must be unalterably convinced that medicine has the right to control its own affairs without outside interference.

Finally, every Indiana doctor should work for the medical organization as a whole. He should belong to his county medical society and pay his dues promptly. He should be active in its business affairs. He should strive in his county society for unity of thought and action, rather than be an element of discord. He should support with whole-hearted enthusiasm the state and national organizations and their officials.

Having organized our forces, then let us bid for public opinion, boldly and unashamed. In this great country of ours, among our national and higher state officials, are many experienced doctors capable of appearing well and entertainingly before state and national meetings. Let them do so. In every state are many men capable of addressing state and civic bodies. Let them do so. In every county are men capable of speaking to still smaller groups. Let them do so. Finally, every individual doctor has his friends and patients. Let him talk to them.

What shall the public be told? Perhaps no one individual has a compendium of all knowledge, but these are some of the things which well might be explained to the laity:

Let us point out to the public how the medical profession, through its own effort and without outside help, has raised its professional standard from the crudities of the Middle Ages to the highly scientific practice of today, that our educational requirements are far superior to most and second to none, that our moral and ethical codes in relation to the public weal are unassailable, and that this so-called advanced civilization which is ours today directly is dependent on the benefits of medical science. Deprive the city of New York of all mechanical and electrical improvements of the past century, and it merely would revert to the days of horse cars and coal oil lights; but take away the discoveries of medical science, then, indeed, pestilence and disease would reduce it to an uninhabitable shambles.

Still further, let us show the public how, through the autocratic administration of a bureaucratic government in the conduct of its Veterans Bureau, not only is there foisted an overwhelming and ever increasing tax burden upon our citizens, but also, by just so much as it is unfair in its competition with the doctor in private practice, by just so much is it degenerating the services which the doctor can give to his patients. In the end, the public always pays.

Let us demonstrate, too, that medical practice neither needs nor is it for the public weal to have

lay control. An intermediary or go-between to bring the patient to the doctor or hospital means a lesser service at a greater expense. Again, the public pays.

Let us prove that experience in the socialization of medicine in England and Germany has been a failure in that it is costly to government, that such medical practice has been degraded, and that the per diem illness among those classes of patients averages more than two and one-half times that of ours. When people are paid to be sick, they remain sick.

Let us publish the fact that for years and years, uncomplainingly, through drastically reduced charges and freely given charity, the doctors have been carrying on their own individual shoulders a vast burden of medical service to the indigent and unemployed, which load, properly and without embarrassment, we readily could ask and force the community tax payer to bear.

If detailed facts are wanted, let us give at least some. The American public spends 525 millions annually for patent medicines and home remedies, drugs of actual or potential harm. This is more than one-half of what they pay their doctors, and 2.7 times what they pay for their physicians' prescriptions. Six times what the public pays their doctors annually is spent on automobiles, three times as much on recreation, 2.8 times as much on tobacco and confections, 75 per cent as much on personal adornment, and one-third as much on the maintenance of household pets.

Finally, let us educate the public that, even though physicians represent only ten per cent of the personnel engaged in the entire health program of the country, still, doctors only are competent and capable of organizing and guiding the work of the subsidiary professional aides. Physicians, alone, fully can comprehend the important influences resulting from changing social, economic, and psychological factors, as they contribute to the causation, treatment, and prevention of disease.

The most outstanding characteristic of any one civilization is change. The rapid growth in knowledge in medical science, plus the development of many highly technical procedures, has added immeasurably to the complexity of the problems of medical care; accordingly, the medical profession stands in the premier position to evaluate these changes. We, alone, can recognize defects in our methods, and we, alone, can remedy them. We, alone, can retain and further extend the fundamental advantages of the American scheme of practice, adapting it to the American philosophy of living.

As the income of the individual rises above the level providing for the bare necessities of life, he finds himself with "optional dollars" for purchases according to taste or appeal, and when analysis is made of what the public pays for other optional luxuries, such as gasoline, candy, cosmetics, toys, etc. (largely by persons of moderate means), it will be found that more of these "optional dollars" logically could be spent for better medical service. It is our problem to show the real value of such service.

Owing to widespread publicity concerning the economic aspects of medical care, the false impression has been created that this cost is unreasonably high, yet in the studies represented, quality of service has been almost uniformily disregarded. When the public is convinced of the value of proper medical care, then the necessary financing will follow.

Now, is there any reason why Indiana doctors should be afraid or ashamed to face the public? No! When the medical history of Indiana for 1933 is written, may it be said that the Indiana doctors were the makers of that history, the shapers of the affairs of men, not mere recorders of passing events!

MEDICAL RELIEF IN KOKOMO

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This article is written with the idea that since Kokomo is primarily an industrial city, and was among the first in Indiana to show the effects of diminished manufacturing activity, a history of the various methods tried for medical poor relief and the final plan adopted may be of value to physicians in other cities where the economic situation is only now beginning to correspond to the crisis in Kokomo two years ago.

In 1929 the trustee made an oral agreement whereby each doctor cared for his former patients, now indigent and asking for help, at a rate about twenty-five per cent less than the standard rate. In addition to those frankly on the bounty of the county, there were a great number who formerly paid their medical bills and were still cared for by their family physicians, hoping to be able to meet their obligations to the doctor as soon as the economic stress was relieved. As the depression continued, more doctors requested their unemployed patients to secure orders from the trustee. When such costs of medical relief had risen to about $1,200 per month, the trustee, in association with the county commissioners, contracted with one doctor to care for all indigents at the rate of $500 per month. Protests by the general body of doctors were of no avail, as the commissioners pointed out that their sole concern was to save about $700 monthly for the taxpayers.

As time passed it was found that this arrangement was not very satisfactory. The number needing medical aid had grown from a few hundred to 2,700 families. It was not physically possible for one doctor adequately to care for 11,000 souls. From humanitarian reasons, other doctors were

making calls on indigent patients for which no payment was received. While, legally, collection could have been made for such emergency work, considerable difficulty was experienced in proving that such services were absolutely necessary.

On the other hand, the contracting doctor, while not doing all the work for which he was legally responsible, was very much overworked and underslept. Diagnoses were hurriedly made and for this reason often incorrect. There was no time for the social amenities to which patients were accustomed. The doctor's private practice grew less. There were many unpleasant scenes wherein he was called to treat people who did not want him but of necessity had to have his services or none. He afterwards told us that he netted very little profit on the arrangement and also that his health had suffered because of the extraordinary demands upon him.

As the year progressed the trustee developed an harassed look. Committees of so-called Reds called upon him and demanded to have their own doctors. He had three or four unpleasant sessions every morning with people, having some member of their family acutely ill and feeling that it was necessary to have the doctor of their own choice. Protest meetings were held in the public square and a great deal of public sentiment was engendered against all the public officials.

After about nine months of the single doctor arrangement, the trustee made inquiries of us as to what procedure we might have to offer to enable each doctor to care for his former patients and still keep the aggregate cost low. Careful investigation of other industrial areas of make-up similar to that of Kokomo disclosed chaotic management in varying degrees. There was no systematic method in vogue. The clinic idea had not worked out well. In general, the policy of greatly reduced rates was the most universal method.

Accordingly, we submitted a proposal calling for a fee schedule at about 50 per cent of the prevailing charge to private patients. We further proposed to have a committee of doctors censor the bills at the end of each month. This plan was rejected. Instead the commissioners sent out letters to each individual physician stating that the township would be willing to pay for medical services at a certain listed schedule. This schedule was placed at about 30 per cent of the normal rates. Our official committee replied that we considered the offer too low and that if any individual physician signed up at this rate, the medical society would not be responsible nor would any censorship of bills by us be undertaken.

To our surprise, four physicians signed up definitely at this rate and several more agreed orally. This arrangement persisted for a month and then it was found that a great many doctors took occasional cases at these prices. The result was that in order for the individual physician to break even, he made many unnecessary calls on cases and the aggregate amount at the end of the month was in excess of the original estimate.

Since this was not satisfactory, the trustee finally turned the whole matter over to the society, telling us, in substance, to handle the matter as we saw fit, taking notice of the fact that the county funds were depleted and that there was a question whether the county could pay any of its bills. By this time the trustee was spending $1,100 per day for groceries, and unemployment was growing. Most of the employment available was for only part time which did not yield enough revenue for a man to pay his doctor. Members of the society were being called upon by the receiver of the defunct seven-million-dollar bank to pay their assessments or to pay off the mortgage on the farm or house they had bought in better times. Insurance premiums were coming due, etc. In fact, economic conditions were such that it was not very difficult to get individual physicians to compose their temperamental differences and agree upon any reasonable plan that might be proposed.

The Iowa Plan

Some consideration was given the Iowa plan which we had in effect in Kokomo for some years in caring for the jail and county infirmary.

It was customary for the society to bid in this work at a lump sum, twelve doctors taking one month each without personal compensation and allowing the revenue to go to the treasury of the society for operating expenses. This plan did not appeal to us for the problem under consideration for two reasons: first, there was a great variation in the amount of poor work normally done by each doctor; second, we did not wish to contract for a definite lump sum with prospects of poor relief increasing as it had been during the past year. The first objection could have been answered by paying each doctor an amount of money in proportion to the amount of bills submitted, but there still remained the objection to a definite lump sum when there were prospects of further increase in poor relief.

The Kokomo Plan

To combat this latter objection we then proposed the arrangement under which we are working at present. We found that estimates prepared by the Governor's Relief Commission showed that in 1929 the medical cost of the total amount of poor relief in one-half of the townships of the state was 6 per cent of the total. The remaining 94 per cent was for food, clothing, shoes, etc. We proposed to guarantee that our cost would be just exactly 6 per cent of any amount that the township might spend. Our amount would be fixed only in relation to the other expenditures. If the township effected a saving by establishing a commissary or in any other means, the medical cost would be reduced in proportion.

This plan appealed to the trustee because the cost of medical services bore a definite relation to

his other expenses and his office ran more smoothly, for all patients were treated by their own doctor. It appealed to the doctors because each doctor retained his former patients and the aggregate cost was such that the trustee would not be tempted to contract privately with any one doctor or small group of doctors.

In the practical working out of this plan it was found necessary to appoint a committee of fair and able doctors to draw up plans by which members were to be guided, and continually to supervise the general operation of the schedule. Certain restrictions were established on non-emergency procedures such as tonsillectomies, herniotomies, haemorrhoidectomies, repair of chronic pelvic conditions and the fitting of glasses for adults. On the twenty-second of each month, bills were to be submitted to the secretary of the medical society at about 50 per cent of the normal rate. The bills were to be audited by a rotating board of censors drawn by lot. All bills were then added together and if they exceeded 6 per cent of other township bills, each bill was reduced by a definite percentage so that the aggregate would represent a 6 per cent level. If we were making this arrangement again, we should, if possible, make the percentage 7 per cent instead of 6 per cent to meet present conditions. Impaired nutrition and slip shod methods of living render more medical service necessary now than in normal times.

Conclusion

We have found that this plan is not satisfactory to every one, but it meets with the approval of the trustee, patients and the majority of the physicians. We enumerate the disadvantages and advantages:

Disadvantages

(1) The allowance at present is inadequate. Because of political manipulation and efforts of individual physicians to secure a separate agreement, it was necessary to accept this amount or none.
(2) Auditing and censoring bills entails a great deal of detailed labor on the part of some members of the medical profession.
(3) There is a tendency on the part of a few doctors to make unnecessary calls and thereby make their bills out of proportion to the necessary work done by other doctors. (A fearless and conscientious committee to audit these bills reduces this difficulty.)

Advantages

(1) It assures each patient that he shall have his own doctor.
(2) Guarantees a flexible amount which corresponds in general with the pay of any contract practice or public part-time job such as county coroner, school inspector, board of health, or industrial insurance. This compensates the doctor in some measure for the calls which he will make regardless of what plan the trustee follows.
(3) Because the total cost is relatively fixed, the trustee will not contract privately with any one doctor or group of doctors.
(4) Keeps down public disturbances. Better service is given to patients as each doctor only averaged 27 indigent families per month.
(5) It keeps the control of medical services within the medical profession.

MATERNAL MORTALITY AND COMMON SENSE*

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To begin a crusade against crime by branding the clergy as high priests of evil and by declaring that churches are a shelter for the altars of iniquity would hardly seem logical. Destroying public faith in preachers and the church by cleverly portraying as present-day faults the ecclesiastical sins of pre-Reformation days does not appeal to even that homeless wandering itinerant, the man in the street, as the best way to attack the sources from which crime springs. To pick out the isolated treasurers of churches and other religious organizations who have defaulted and embezzled as the point upon which to center a campaign for economic reform has no profound appeal to reason.

This, however, is exactly the position taken by Paul de Kruif concerning the health of mothers and the risks of maternity in an article which appeared in the March, 1932, issue of the "Ladies' Home Journal." Although the ethical medical profession and our hospitals are the very best institutions we have for safeguarding the health of mothers at the time of childbirth and in spite of the fact that they seek constantly to improve their art and to convert people to take advantage of the remarkably efficient facilities they have to offer, the article by de Kruif certainly promotes skepticism if not actual destruction of faith in the medical profession and hospitals so far as obstetrics are concerned. Worse still, there is no statistical evidence, at least in Illinois, to support the statements upon which he bases his accusations and fears.

Furthermore, child-bed fever, the subject of the de Kruif article, is a minor health risk under modern conditions in respect to ultimate consequences to mother, child, and race, compared with such things as syphilis, tuberculosis and poor racial stock. All of these things are involved in reproduction and are susceptible to a large degree of control. While child-bed fever, erroneously so called in about one-half of the fatal cases, caused less than 200 deaths in Illinois during 1930, over

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one-half of which had no relation to obstetrical care because they were preceded by abortion, tuberculosis caused 1,402 among women of child-bearing age (15 to 44 inclusive) and left over 10,000 active cases alive among this group of women to spread the disease to children. Syphilis is certainly widely prevalent. This disease is present in a far greater number of mothers than child-bed fever ever attacks, and probably is the inciting cause of involuntary abortion in many instances. Here are two specific problems of large magnitude and susceptible to solution over which an able writer like de Kruif might profitably spend some thought and effort.

Now for the statistics, de Kruif says,

"Even in our land, where child-bed fever is the worst medical scandal....."

Well, in 1930, a typical year and the most recent for which detailed statistics are available, there were 199 deaths in Illinois ascribed to child-bed fever or puerperal septicemia as this condition is technically called. Out of that number 107 or 54 per cent were preceded by abortion which was admittedly self-induced in 35 cases. Abortion not only creates the most favorable conditions for the onset of septicemia but usually requires medical procedures which increase far above normal delivery the risk of septicemia. Furthermore, a case of abortion has no more relation to obstetrics than does a case of appendicitis or hernia.

The other 92 of the 199 fatalities from puerperal septicemia in 1930 were scattered through 39 counties. Furthermore, the mother was attended at the time of childbirth by someone not a physician in one out of each ten cases where septicemia resulted in death of mothers who went through the full term of gestation. After making allowance for all of these things the risk of fatal puerperal septicemia in Illinois in 1930 among patients attended by licensed physicians is reduced to 81 out of 129,937 mothers who gave birth to living and 4,324 who gave birth to stillborn children, a matter of less than 1 per 1,600 cases of confinement. Manifestly, human nature being what it is, the loss of 81 out of 134,261 mothers whose experiences involved the obstetrical services of some 7,500 out of the 11,382 licensed physicians in Illinois could not by any stretch of the imagination be branded as a "medical scandal."

The Illinois statistics are not peculiar in respect to abortion as a very great factor in deaths registered against puerperal septicemia. Miss Grace Abbott, chief of the United States Children's Bureau, who of all people in the country would be most anxious to put her finger on the principal cause of child-bed fever, pointed out in an address delivered before a meeting of state and territorial health commissioners at Washington, April 29, 1931, that:

> The study of maternal mortality made by 15 states and covering all the deaths from puerperal causes within 13 states for the two years 1927 and 1928, and within 2 states for the one year 1928 shows that of the 7,380 deaths due to strictly puerperal causes, abortions preceded 1,824, or 25 per cent, of the whole number of deaths. Puerperal septicemia was the cause of 1,324 or 73 per cent of the 1,824 deaths following abortions. Seven hundred and ninety-four deaths followed induced abortions. Of this number 722, or 91 per cent, were due to puerperal septicemia. Forty-five per cent of all the deaths included in the study assigned to puerperal septicemia in the states and the years of the study were preceded by abortions, and induced abortions caused one-fourth of all the deaths assigned to puerperal septicemia. Clearly, the conclusions are that appreciation of the dangers of induced abortions would reduce by approximately one-fourth the total number of deaths (2,948) from puerperal septicemia.

Again, de Kruif, in speaking of the splendid work and observations of Dr. J. B. DeLee, makes the following statement:

> "In all the general hospitals he's worked in he has seen child-bed fever. DeLee comes right out flat-footed telling of present disasters in general hospitals, whispered about among doctors, never heard of by us plain folks. In this class-A general hospital an outburst of child-bed fever with ten cases stricken, six gravely, three dying. In that one twenty cases—six dying. And so on all over."

Chicago Statistics

The last statement is literally not true. Outbreaks of child-bed fever in general hospitals are not frequent nor do they occur "all over." In the days of Semmelweis and of Oliver Wendell Holmes, on whom de Kruif leans heavily for his statements, and even somewhat later there might have been ample grounds for that statement but not today. Illinois statistics are clear and unequivocal on this point. Of the 199 deaths charged against child-bed fever, 76 occurred in Chicago and 123 down-State. Among those in Chicago, 37 were preceded by abortion, a fact not only testified to on the death certificate but also by the name of the coroner who signed each of these 37 certificates. Four of the other 39 took place in homes, 1 on the way to a hospital and 34 in 25 different hospitals. Nineteen of these hospitals had 1 death each and 1 of these 19 was the Chicago Lying-In Hospital, which de Kruif correctly held up as a model. Four of the hospitals had 2 each with no 2 in any hospital occurring within 2 months of each other. At the Cook County Hospital, which accepts only charity patients of whom a large percentage are colored and which has on its attending staff the ablest physicians in Chicago, there were 7. Four of these occurred at dates separated by more than a month each. Three occurred during the month of September. One of these 3 required an operation that

opened up the whole abdomen and another of the 3 had an infection to which the puerperal septicemia might well have owed its beginning. The third involved a still birth, the certificate of which was signed by a physician who designated nephritis and hypertension as the cause of the still birth. Another physician signed the death certificate of the mother. Thus arises a question as to whether child-bed fever was involved at all in this third of the three September deaths attributed to puerperal septicemia. Certainly there was no "outburst" of puerperal septicemia. Furthermore, no physician except a resident physician at the Cook County Hospital whose business is to handle emergencies signed more than one of the 34 certificates which relate to deaths that may be justifiably said to have involved child-bed fever and which occurred in hospitals. Thus in Chicago, where 68 per cent of the births took place in hospitals, the evidence is clear that no "outburst" of child-bed fever occurred in any hospital and no "medical scandal" enshrouded the experiences of motherhood.

Down-State Experience

As for the 123 down-State deaths, 84 occurred in hospitals and 39 in homes. Of the 84 that took place in hospitals, 49 were preceded by abortion and 13 of the mothers among the other 35 had given birth to children at home and had been removed to hospitals only after complications developed. This leaves only 22 deaths attributed to puerperal septicemia which involved in any way the obstetrical services that obtain in the hospitals. How many of the 22 maternity patients had developed complications before being removed to the hospitals for delivery could not be ascertained from the certificates. There were, however, 5 who required surgical operations and 7 others in whom there were complicating conditions other than septicemia and which may have been important factors in bringing on septicemia. This reduces to 9 the number of deaths from septicemia which occurred among apparently uncomplicated maternity cases in down-State hospitals during 1930 and there were 25,870 live births which occurred in down-State hospitals that year. This is a risk of a trifle more than 1 per 3,000 cases.

The 84 deaths attributed to puerperal septicemia which occurred in down-State hospitals were distributed among 62 different hospitals. There were 42 hospitals which had one each including those preceded by abortion. There were 15 hospitals which reported 2 each but in 8 of these one or both deaths were preceded by abortion and more than a month elapsed between the time of the death of the 2 cases in each of the other 7 hospitals. There were 4 hospitals, each of which reported 3 deaths from puerperal septicemia during 1930. All 3 deaths were preceded by abortion in 2 of these hospitals. One of the 3 deaths in another was preceded by abortion and the other 2 occurred several months apart. In the fourth hospital, 2 of the 3 deaths were of patients who had given birth to children and developed child-bed fever at home before removal to the hospital. Furthermore, these 3 deaths occurred respectively in February, August and November.

In the homes of Illinois exclusive of Chicago there occurred 39 deaths among women attributed to puerperal septicemia. But there were 13 deaths from this cause in the down-State hospitals of women who had given birth to children in their homes before being removed to the hospitals. These 13 make a total of 52 deaths chargeable to conditions which developed in the homes and to which the hospital obstetrical facilities had no relation whatever. Among the 52 were 12 patients who had experienced abortion, 2 who had suffered from miscarriage and 2 whose babies were still born. This reduces to 36 the number of deaths from septicemia among apparently uncomplicated maternity cases which involved home care of the mother at the time of birth. Since 45,984 live births occurred in the homes the number of deaths was at the rate of about 1 per 1,260 live births. However, there were two cases in which the mother had no medical service so the risk of fatality where medical obstetrical service was concerned falls somewhat. In other words the risk of fatal child-bed fever among mothers whose babies were born in hospitals was less than one-half what it was among those who stayed at home for this important event.

As in the Chicago experience, only one down-State physician exclusive of coroners, signed more than one certificate of death on which puerperal septicemia was designated as a factor. This physician signed 2. The fatal condition of one of these 2 patients was preceded by a miscarriage which involved an infection independent of the septicemia.

In the light of these data it seems clear that no "outburst" of child-bed fever occurred in any hospital in Illinois during 1930 although 65,340 births took place in the hospitals of the state in that year. Nor was 1930 an exceptional year. This is shown by an analysis of the statistics for a period of five years for the seven cities of Chicago, Decatur, Evanston, Oak Park, Peoria, Rockford and Springfield where practically 70 per cent of all births occur in hospitals. In these cities where an aggregate of 350,895 births occurred during the five years of 1926-1930, the deaths attributed to child-bed fever, including those preceded by abortion, were at the rate of 2.2 per 1,000 live births. In the state exclusive of these cities where an aggregate of 313,108 took place during the five-year period, 72 per cent of which occurred in the homes, the death rate from child-bed fever was exactly the same, 2.2 per 1,000 live births. This completely absolves hospitals as incubators of child-bed fever.

Again, de Kruif says:

> "If they all—like Semmelweis—cared down deep, about these mothers dying. Then there'd be no excuse, no alibi."

The Physicians Involved

No physician enjoys signing a death certificate, least of all one that might cast reflection upon his professional efficiency or skill. If for no other reason, selfishness pure and undefiled, drives him for the sake of a livelihood to do all that he can to prevent a death. There are 11,382 physicians (1930 figures) licensed to practice medicine in Illinois and it seems reasonable to estimate that two-thirds of these, or about 7,500, practice obstetrics. These physicians have officiated at the births of over 1,300,000 babies during the last ten years. In that time 3,254 deaths (these are the figures of the federal bureau of the census, which are always liberal) were ascribed to puerperal septicemia. According to the 1930 analysis one-half of these were preceded by abortion. Thus ordinary obstetrical service could not have been involved in more than 1,627 deaths from puerperal septicemia in ten years. That gives an average of less than 1 death, where obstetrics might have been involved, from puerperal sepsis in ten years for each 4 physicians. In 1930 there was only one death from puerperal sepsis which involved ordinary obstetrics, including difficult labor, for each 81 physicians who practice in Illinois. At the rate which has prevailed during the last decade in Illinois it would take nearly 25 years for child-bed fever to cause enough deaths to average 1 per practicing physician in the state even when those which are preceded by abortion are included in the calculation.

But, says de Kruif:

> "Of course, the great mass of our mothers are lucky: They have their babies at home."

That statement is far from the truth so far as the mothers in Illinois are concerned. In 1930, for example, 65,340 of the 129,937 live births reported in Illinois occurred in hospitals against 64,597 in homes. In Chicago, 68 per cent of the births occurred in hospitals in that year. In six leading down-State cities an aggregate of 84 per cent of the births occurred in hospitals in that year. The main factor which determines whether or not a majority of births take place in hospitals seems to be the availability of hospital facilities. In Oak Park and Evanston, for example, over 97 per cent of all births occur in hospitals. In Rockford, 82 per cent of all births occur in the hospitals; in Springfield, 75 per cent; Chicago and Peoria, 68 per cent; Decatur, 64 per cent. Furthermore, as shown above, the death rate in down-State hospitals in Illinois from child-bed fever which involved the hospital obstetrical facilities, was about one-half what it was in the homes.

Another statement by de Kruif is:

> ".....so that child-bed fever kills one out of eighteen of all married women dying between ages fifteen and forty-four."

That statement is not true for Illinois. An analysis of the death certificates for 1930 shows that 5,171 married women, ages 15 to 44 years inclusive, occurred in that year. Of these, 176 or one in every twenty-nine deaths, were ascribed to puerperal septicemia. This ratio is given on the basis of all deaths ascribed to puerperal septicemia, including those that were preceded by abortion. When those involving abortion are eliminated only about 1 out of each 60 deaths among married women between 15-44 years of age result from child-bed fever.

Finally, de Kruif points to Dr. G. C. Thornton of Lebanon, Kentucky, as a physician apart because,

> "In twenty-seven years he's not had a single death from child-bed fever,"

although engaged in general practice. Dr. Thornton is to be commended highly for this record but it is by no means an unusual record. It was pointed out above that if equally divided among all physicians in Illinois the deaths ascribed to puerperal septicemia would not average more than one per physician in twenty-five years, even when those deaths that are preceded by abortion are included. Since some physicians have wider practice than others it follows that some would experience a larger percentage of the losses from puerperal septicemia than others. Thus many general practitioners doubtless have gone through a full, long life of medical practice without ever facing the unhappy duty of signing a certificate with puerperal septicemia designated as the cause of death.

Furthermore, de Kruif in holding up as a blot against the medical profession of Kentucky the reported loss of 308 women from puerperal septicemia fervently regrets, concerning the report, that:

> "When it gave the deaths, if it had just given the names of the doctors who had attended those 308 cases, 'Then we'd know where to begin work,' said Thornton."

In the first place it is probable that fully one-half of these cases were either preceded by abortion or were attended at the time of birth by a mid-wife or neighbor. In the second place every death certificate is very carefully scrutinized and studied by the state public health authorities. No physician or other practitioner of obstetrics could be involved in any significant number of deaths from puerperal septicemia without attracting the attention of the public health authorities to that fact. No community and no hospital could for very long be the place of an excessive death rate from puerperal septicemia without attracting the attention of the health authorities.

Means of Improvement

After eliminating abortion, about twenty-five per cent of which is self induced and a goodly percentage of the remainder of which results from such preventable and controllable infections as syphilis, it is clear that the danger from child-bed

fever is far less than the risk of death encountered in tuberculosis. It is safer for a mother to have a baby than it is for her to drive around in an automobile. Having a baby under the care of a reliable physician and in any reasonably well managed general hospital is safer for the mother, so far as child-bed fever is concerned, than the risk of fatal accident. The risk of being murdered with malice aforethought is greater for the women of child bearing age (15-44 years inclusive) than is the risk of child-bed fever when abortion is excluded. After eliminating those cases in which abortion was involved, puerperal septicemia caused 92 deaths in Illinois during 1930. Homicide was charged with 108 and accidents with 258 deaths among women of child bearing age in that same year. Of these accidents, 216 were due to automobile mishaps.

"Whispering" campaigns against doctors who sign certificates with puerperal septicemia specified as the cause of death is suggested by de Kruif. His plan needs neither emphasis nor stimulation in order to bring about adoption. The doctor who stoops to criminal abortion is usually a better known character than many practitioners of untarnished integrity. The doctor who sees in a five dollar bill the symptoms of a cold which requires a prescription for whisky as an offset to serious complications needs no radio broadcasting facilities as an advertising medium. In like manner the other attributes of skill and integrity which attach to the character of physicians are communicated.

Every sane person deplores the loss of a mother's life, especially at a time when the welfare of a child depends upon it. When the loss results from a preventable cause, the event is doubly grievous. This fact, however, is no logical reason for laying at the door of the delivery room all blame for mortality attributed in statistical tables to puerperal septicemia. It is more probable that neglect (either innocent or wilful) on the part of prospective mothers in the employment of medical skill and hospital facilities during the prenatal period results in a great many more childbirth complications and disasters than does incompetent medical and hospital obstetrical service.

It is a strange thing that many intelligent people, both within and outside the medical profession, seize upon the notion that the United States has the highest maternal death rate in the world and shout from the housetops their implicit faith and belief in that statement. The gross statistical tables indicate that the statement is true. An analysis of all the factors involved in computing the statistics shows that it is not true. It is one thing to run through a column of numerals set opposite a list of various causes of death. It is quite another to examine one by one the certificates of death and to bring into the picture the various factors and circumstances involved in each death. The two methods frequently lead to surprisingly different conclusions.

THE CHIROPRACTIC SITUATION

Frank Jett, M. D.
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Terre Haute

Medicine has come down through cults, -isms and dogmas, occasioned by ignorance. It has only been about fifty years since all that was necessary to practice medicine and be responsible for public health was to read in a doctor's office for six months and ride around with him to see his patients. Gradually this was extended to require some fundamental education and schooling. Then came the time of the different "paths" in medicine, the allopaths, homeopaths, eclectics and many others. These were attempts to classify diseases and modes of treatment under some particular principle. Scientific medicine finally proved, without a doubt, that there is no such thing as a "path." Thus arose the so-called regular practitioner, or the really scientific medical man. At this time the country was filled with different medical schools teaching the "paths" in great measure, regardless of standards, and it has been one of the most difficult tasks of medicine to rid itself of these schools and even to await the passing of men who were not trained, but who believed thoroughly in them. Regular medicine did proceed, raised the standards, and there was then another thing which took root to injure the standing of medicine. This was from within and came from the bootlegger or under-standardized backdoor school of medicine which graduated men who knew nothing. These schools went so far as to sell diplomas and give out lists of examination papers and many other practices. They flourished for some time and put their output on the market to reduce the standard of medicine and, of course, with no good purpose so far as health and society were concerned.

Then came the Committee on Medical Education. The state laws were stiffened, making the different schools come up to standard. The entrance requirements were raised, until now we stand with practically a state-owned and controlled medical school in every state in the Union, with many other schools fully coming up to their requirements. Today these schools are graduating young virile men who are picked from the upper third of our high schools, given adaptability tests and given a fundamental education in scientific branches, honestly studied and honestly passed. They represent practically three years in a college. Many of our schools are requiring four years in college with stated branches to enter medical school. These standardized schools today are requiring the student to attend four years, of nine months, i. e., the computed hours actually spent in class, laboratory and in study amount to approximately 10,000 hours. Most states are adding to this one full year in a hospital, so that today the United States is yearly graduating and sending out 5,000 trained

men who are the equal of all the world in medicine. The United States has approximately 3,000 deaths among the medical profession every year. The recent Committee on Medical Cost in the United States reports there are 25,000 too many doctors in the United States, and these are being added to at the rate of 2,000 a year! The number of people per doctor in the United States is 1 to 750, and still there are those who talk about the medical profession being a "trust," or trying to keep people out of the medical profession. It certainly would be a poor form of "trust" to have an excess of this kind and keep adding to it.

These things the medical profession accepts as its duty and its privilege:

First, to keep the standards of medical education high, at least as long as there are sufficient medical men to care for all the sick;

Second, to protect society and the public against all isms, dogmas and cults that have no foundation in fact;

Third, to fight for all those things that are good for public health;

Fourth, to further the progress of preventive medicine in every possible way; and

Fifth, to analyze, construct and, through research, develop such things as are good in the handling of disease and to give these freely to society without reward.

It is obvious that this program is best for the public at large.

The latest, but let me warn you not the last, attempt to lower the standard of the healing art, was the proposed chiropractors' bill asking the Indiana State Legislature to enact special legislation, creating a board to license their cult to come into Indiana and thus *reduce the standard of those treating the sick.*

Chiropractic had its origin in Iowa about 1894, when a "magnetic healer" named Palmer claimed he cured a janitor of deafness by manipulating the spine. From this came the dictum, "All disease is caused by 'subluxation' of the spinal vertebra and all disease can be cured by reducing this 'subluxation.'" He was followed by his son, B. J. Palmer, who admits he was a graduated practitioner of chiropractic at twelve years of age without a common school education.

The Palmer School, "Fountain Head of Chiropractic," has been a wonderful success in a financial way. Students without number were given certificates of attendance, even at one time by correspondence—this always for a substantial fee.

Quotation from sworn testimony by B. J. Palmer:

"1895 to 1897 course was two weeks—cost $500.00 cash.

"1897-1900 course was one month—cost $500.00 cash.

"1901-1902 course was two months—cost $500.00 cash, not more than one-half of which could be paid in bankable notes.

"1902-1903 course was three months—cost $500.00 plus notes as above.

"1903-1904 course was six months—cost $500.00 plus notes as above.

"1904-1906 course was nine months—cost $500.00 cash. No notes taken.

"1906-1910 course was nine months—cost $100.00 cash.

"1910 course was twelve months—$150.00 cash.

"1911 course is twelve months—cost $200.00 cash.

"It will be seen from the above tabulation that we kept giving more time, which is more service—without charging more for it—in fact, we kept reducing our income. We are now working back to the standard tuition ($500.00) but we are proportionately adding length of time * * *." (A Chiropractic Catechism).

It is admitted under oath in court records that the laboratory equipment was not equal to the country high school, nor that those teaching had any qualifications.

Facts About Chiropractic*

"In 1920, according to an investigation of the American Medical Association, there were seventy-nine chiropractic schools, of which one, by far the largest, had over 2,000 students and was graduating new chiropractors at the rate of 1,500 a year. In 1927 there were only forty chiropractic schools, with a total attendance of not more than 2,000. At the present time there appear to be twenty-one active schools, with a probable attendance of 1,400 * * *

"The following statement by a chiropractor at a United States Senate committee hearing is pertinent: 'In fact, we had at one time 200 schools in the State of Michigan. They would start up with anything, in a back parlor for instance. We had a man over on East Capitol Street a few years ago who was advertising to teach chiropractic in 30 days for $10 * * *.'"

A Tabulation from Reports of the Inspector of the Pennsylvania Bureau of Medical Education and Licensure.

PALMER SCHOOL

Buildings	Four, crowded
Access to hospitals	None
Dispensary facilities	
Admission requirements	Common school
Anatomy dissecting	Only dogs dissected
Histology	Very incomplete
Embryology	Not taught
Surgical anatomy	Not taught
Physiology	Lectures only
Physiologic chemistry	No equipment
Chemistry, inorganic and organic	No equipment for teaching
Bacteriology	No equipment
Pharmacology	Not taught
Microscopic diagnosis	Not taught
Medicine	Not taught
Surgery	Not taught
Anesthesia	Not taught
Class Rooms	Four
Clinical amphitheater	Two
Medical library	None
Microscopes	Twelve
Microscopes having oil immersion	One
Reflectoscopes	Yes
Stereopticons	Yes
Obstetric manikin	Yes
Maternity work	Lectures only
Charts	Large supply
Models	Yes

Pathology—Pediatrics—Nervous and Mental diseases—Gynecology—Eye, Ear, Nose and Throat diseases—Dermatology and Genito-Urinary diseases * * * All taught only from the chiropractic standpoint as it is related to certain spinal "lesions".

* Bagnall, *New Eng. Journal of Medicine*, Nov. 3, 1932.

Is this not ridiculous when at the same time the state of Indiana was maintaining its School of Medicine with buildings and equipment worth millions and more than 100 fully trained teachers, requiring four years of nine months of solid studies?

The State Board of Health spent nearly $200,000.00 last year, a large part of which was used to prevent the spread of communicable disease. To quote again from Bagnall:

"How foolish it is for a community to maintain an elaborate machinery to prevent the spread of certain communicable diseases, and yet permit individuals to practice who are unable to differentiate diphtheria from pneumonia, or scarlet fever from measles. The matter is made worse by the fact that chiropractors advertise themselves as, and are known as, doctors, and a large proportion of the population, unaware of the connotations of the letters M. D. and D. C., assumes that a doctor is a doctor, and that all are equally trained in the art of healing. This is even more true when a state licenses chiropractors, for the average layman is then apt to assume that the state vouches for their competency."

Extracts From the Decision of the Supreme Court of Michigan in Janssen v. Mulder, Decided October 1, 1925 (205 N. W. 159)

Plaintiff as administratrix of the estate of her deceased child, Laverne, brings this action to recover the damages incident to her death, charging malpractice on the part of the defendant. The defendant attended the Palmer School of Chiropractic at Davenport, Iowa, for fourteen months, and received a graduation diploma * * *.

The child died Tuesday morning at 5:00 o'clock.

"He had been there the night before—it seems to me around 7:00 or 8:00. The last time he gave her a treatment he adjusted the spine, as far as I know. I don't know, of course, what he calls it—it seems as though he stretched her neck * * *. She had quite a pain in her throat, didn't eat anything. She was quiet a good share of the time. At last it was hard for her to breathe. I fanned her the whole Monday night before she died in order to keep her breathing."

On cross examination, she testified:

"After treating her he told me she had a good case of tonsillitis. A few days later on he turned it into quinsy * * *. He said that in years to come, in a very short time, medical doctors would be entirely wiped off the map—they would all be chiropractors. I took it for granted that the chiropractor knew just as much as the medical doctor."

The defendant, called for cross examination under the statute, testified:

"I gave an adjustment of the spinal column, one specific vertebra, which I adjusted, and nothing more and nothing less. By an adjustment I mean where one vertebra is out of alinement compared with the one above and the one below. I adjusted to put it in juxtaposition with the one above and the one below."

Q. Do you know what the normal temperature is?

A. 96.5. The only way a temperature of 104 is worse to me is that it is the result of some cause. We do not pay much attention to temperature only as we locate it on the spine. I never took the temperature of this child.

Q. You maintain now that this was not diphtheria, don't you?

A. As far as my knowledge of things is concerned, no. I have never studied diphtheria. We do not study it from a medical standpoint. I have never treated a case, to my knowledge. I didn't know anything about it. I didn't give any treatment for it."

After the child's death, an autopsy was performed by Dr. LeRoy, one of the coroners of the county. He testified that she died of diphtheria.

Suppose we allow the chiropractor to testify in his own behalf, most of it by B. J. Palmer who devised it. Coming from the "Fountain Head," under oath, we have the right to infer he believed his answers to be true.

Extracts from the Evidence in the Case of Brown v. Shyne, Supreme Court, Oneida County, N. Y. May, 1924

James G. Greggerson, being duly sworn, testified as follows in behalf of the defendant:

Q. Are you a chiropractor?
A. I am.
Q. Do you know what the theory of chiropractic is?
A. I do.
Q. How far did you get in the public school?
A. I did not finish the last grade.
Q. So your schooling terminated at the end of the seventh grade?
A. No, it terminated during the eighth grade.
Q. You never attended high school?
A. No.
Q. After your common school education ended, where did you go?
A. I went to work on a farm.
Q. What are you engaged in now?
A. Lecture work.
Q. For what?
A. For the Universal Chiropractor's Association.
Q. What are your duties as lecturer for the Chiropractors' Association?
A. To give public lectures on chiropractic.
Q. Do you also testify as an expert witness in cases?
A. Sometimes.
Q. Can you cure cancer by readjustment of the spinal vertebrae?
A. Yes.
Q. Can you cure cancer of the stomach and liver and bladder by readjustment of the spinal vertebrae?
A. Yes.
Q. Can you remove a tumor of the spinal cord by readjustment of the spinal vertebrae?
A. Yes. I will have to condition that last answer.
Q. Well, what is your condition?
A. On the nature of the tumor.
Q. Could you cure cancer of the spinal cord by readjustment of the spinal vertebrae?
A. Yes, if you got it in time.
Q. Could you cure cancer of the eye by readjustment of the spinal vertebrae?
A. Yes.
Q. Tuberculosis?
A. Yes.
Q. Could you cure tuberculosis by readjustment of the spinal vertebrae?
A. Yes.
Q. How about smallpox?
A. Yes.
Q. Diphtheria or scarlet fever?
A. Yes.
Q. Typhoid fever?
A. Yes.
Q. Diabetes?
A. Yes.
Q. Heart disease?

A. Yes.
Q. Drowning?
A. No.
Q. Do you believe, doctor, in the germ theory disease?
A. I do not.
Q. Do you believe, then, in vaccination for smallpox?
A. I certainly do not.
Q. Or antitoxin for diphtheria?
A. I certainly do not.
Q. Or neosalvarsan or 606 for syphilis?
A. I do not.
Q. Or insulin for diabetes?
A. No, sir.
Q. So you don't make any diagnosis of the complaint?
A. No.
Q. Do you know what causes the growth of cancer?
A. Yes, expansion.
Q. Expansion of what?
A. Functional expansion by pressure on a nerve.
Q. Can you cure hydrocephalus, or water on the brain?
A. Yes.
Q. You can cure water on the brain by adjustment of the vertebrae?
A. You can correct the condition that causes it.
Q. Insanity?
A. Yes.
Q. Imbecility?
A. Yes.
Q. Is imbecility a functional disturbance?
A. Sometimes.

Extracts from the Testimony of B. J. Palmer, President of the Palmer School and Infirmary of Chiropractic, Concerning Chiropractic, February, 1921. In the Supreme Court of Alberta, Judicial District of Edmonton

Q. Doctor, did your school advertise or put out a correspondence course at any time?
A. It did.
Q. When.
A. I am not certain as to the time, but as my memory serves me, it was about 1908 to 1910. It ran for about a year and one-half only.
Q. How many students did you have take that course?
A. I would say approximately 100.
Q. When was the first dissection you ever did there?
A. In 1908 as I remember it.
Q. Did you have any bodies for dissection in 1910?
A. Yes.
Q. How many.
A. One or two.
Q. Did you have any in 1911?
A. One or two.
Q. Where is your dissection room?
A. Usually held off the school premises.
Q. So that all of the dissection work on human bodies has been done at the undertaking parlors of Ed Horrigan, has it?
A. Yes.
Q. Now, doctor, on this subject of anatomy, I think you said you dissected some animals besides human bodies. Where was that work done?
A. That was done in the barn at the rear of the premises of the school property.
Q. How many sheep were dissected, doctor, during that period?
A. I suppose as high as three or four a year.
Q. Have they dissected any sheep since 1913 or 1914?
A. To my recollection they have not.
Q. Have you ever had any deliveries in pregnancy cases?
A. A very, very limited number.
Q. How many?
A. I suppose a half-dozen.
Q. When were these?
A. In the early years, possibly before 1915.
Q. Do you remember when the last one was?
A. No, I don't.
Q. Have you any hospital facilities there at all for taking care of such work or obstetrical work generally?
A. None whatever.
Q. Do you teach, or did you during the years in question, teach the germ theory of disease?
A. No.
Q. You don't spend any time teaching that?
A. Not the germ theory of disease.
Q. Did you spend any time studying it in microscopy or any other work of that sort?
A. Not the germ theory of disease.
Q. Did you spend any time studying germs in histology or microscopy or any of your other classes?
A. A small amount of time was spent on studying germs, yes.
Q. About how much time?
A. Oh, possibly four or five hours a year and that was more than it was worth.
Q. What amount of time did you spend as to the treatment or cure of germ diseases during those years?
A. None.
Q. Well, did your school teach during those years that gonorrhea was caused or accompanied by a subluxation?
A. We did.
Q. And did you teach your students to give adjustments for that condition?
A. We taught him that it could be done. Now whether he did it or not was up to his discretion as to whether he wanted to take that class of cases or not.
Q. How about the treatment of boils or abscesses and things of that nature?
A. That is not traumatic, it is pathological, and we teach the adjustment for those conditions.
Q. And what particular vertebra did you teach them to adjust for lice on the head, if any?
A. The adjustment for any scavenger would depend entirely upon where the scavenger was.
Q. Well, take scavengers such as lice on the head: What vertebra would you adjust for those?
A. In the cervical region.
Q. And suppose you had body lice in the groin, what vertebra would you adjust for those?
A. In the lumbar region.
Q. You have never seen one spine that didn't show some subluxations?
A. That is correct.
Q. Have you examined a great many spines on persons who were apparently well, as well as those who were diseased?
A. I haven't seen an apparently well person yet; they are all sick more or less.
Q. Well, have you ever examined anyone that you, yourself, pronounced to be well?
A. No, because I have never seen such an individual.
Q. Have you any chemical laboratory, doctor?
A. So meager that it is not worthy of the name.

Chiropractic

State of Wisconsin v. S. R. Jansheski Milwaukee, December, 1910.

B. J. Palmer, being duly sworn, testified to the following:

Q. And you have been studying chiropractics sixteen years?
A. I have.
Q. Then you began the study of chiropractics at the age of 12?
A. At the age of twelve I was practicing in the field as a practitioner.
Q. What education had you up to that time?

(To be continued in the May issue.)

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APRIL, 1933

EDITORIALS

LYSOZYME

In 1922, Fleming[1] of England discovered a remarkable bacteriolytic ferment normally present in many tissues and secretions in the body. Its characteristic is that it dissolves certain bacteria with great rapidity. This lytic property with the enzymic nature led to its name of lysozyme. It is a very stable substance as enzymes go, unaffected by aerobic or anaerobic conditions and acts best in a neutral or slightly alkaline medium, between 37°C and 55°C. It is unaffected by the digestive ferments. The airborne bacteria and gram-positive cocci that get into the gastro-intestinal tract are acted upon by its lytic action while the gram-negative flora of the colon-typhoid group are very susceptible to its bacteriostatic and bacteriocidal effects. However, the aciduric gram-positive types considered characteristic of the normal stool are unharmed by this lytic enzyme.

Egg white is found very rich in lysozyme. It has been used to some extent in certain eye inflammations. The gastro-intestinal contents of newborn chicks are found very rich in lysozyme but after 72 hours it is entirely gone. The enzyme is not present in normal urine, cerebro-spinal fluid and perspiration. Human tears are very potent in lysoyzme, which would explain the relative rarity of eye infections considering the constant chance at infection from all kinds of organisms. It has been found that a 75% tear solution does not inhibit bacterial growth. Tearing causes a drop in thirty to sixty percent of the normal amount of lysozyme in tears and after three hours of tearing the eye becomes susceptible to infections. The normal titer soon returns after tearing stops which may account for the beneficial effect of atropine in eye infections. Much interesting work is being done on the relation of active eye treatment to the normal lysozyme content of tears.

Work is now in progress on the role of lysozyme in the intestinal flora of infants. Early work has been done by Rosenthal and Lieberman[2] and it is now being carried on by Prickett, Miller and McDonald.[3] The latter groups have investigated the milk of many species of mammals and the stool of the offspring. Of eleven species, human milk was the richest in lysozyme. There was definite lysis in dilution of 1:1,000,000 in one specimen and this in a woman still nursing her baby at twenty-one months. Human breast milk was found to be in general one hundred times as potent in lysozyme as cow's milk.

In studying the stool of infants it is found that at birth the intestinal content is sterile. It soon becomes contaminated after birth by air-borne bacteria, but in the breast fed infant this implanted flora disappears at the third or fourth day and the normal gram-positive stool develops. It was found then that the stools of infants fed on breast milk were rich in lysozyme while this was not found when the infants were artificially fed. However, milk of a species fed to the young of that species caused the lysozyme to be demonstrable in the young's feces in most species. One would conclude that the lysozyme of a mother's milk is essential to the normal development of the intestinal flora of the young and that, in the human infant, human breast milk is essential to the development of a normal gram-positive stool; also to protect the intestine from invasion by the air-borne organisms and the colon-typhoid group giving the gram-negative stool. There was a characteristic relation in the gram-positive to gram-negative ratio of the stools depending on the lysozyme content of the breast milk of the various species.

The great advantage of breast feeding to the newborn infant, and the therapeutic value of mother's milk or human breast milk, in instances of infectious diarrhoeas in infants is evident.

[1] Fleming, Alex.: On a Remarkable Bacteriolytic Ferment Found Normally in Tissues and Secretions. Proc. Roy. Soc., Ser. B., *93*: 306-17 (1922).

[2] Rosenthal, L. and Lieberman, H.: The Role of Lysozyme in the Development of the Intestinal Flora of New born Infant. Journ. Inf. Diseases. *48*:226-235 (1931).

[3] Paul S. Prickett, Norman J. Miller and Francis G. McDonald: Journal of Bacteriology. *25*:No. 1, 61-62 Jan. 1933. The Lysozyme Content of Milk from Various Species and Its Relation to the Fecal Flora of Their Nurslings.

BACTERIOPHAGE AS A THERAPEUTIC AGENT

It is now approximately sixteen years since d'Herelle began to make his reports concerning the matter of transmissible bacteriolysis which has come to be called the Twort-d'Herelle or bacteriophage phenomenon. At present there is not the least doubt that as a laboratory experiment it is a very striking and convincing fact. With regard, however, to the determination of the exact nature

of the process and the therapeutic application of the same, there still remains considerable uncertainty. It is our purpose in an editorial of this kind merely to suggest rather than to discuss the various possibilities. Four theories as to the nature of the bacteriophage have been proposed. First, according to the d'Herelle theory, it is a living ultramicroscopic organism which destroys bacteria somewhat as they destroy us. Second, the enzymatic theory holds that bacteriophage is an enzyme which is capable of reproducing itself and that bacteriophage does not exist in definite organized particles unless you regard the molecule of the enzyme as being such. Third, the monogamic theory which has been proposed by Dr. Hadley of the University of Michigan holds that bacteriophage is a phase in the life cycle of the organism or at least is related to the life cycle of the organism. According to this idea the bacteriophage arises from the culture itself. Fourth, there has recently been proposed a theory by certain European workers that bacteriophage is an inanimate chemical substance. In support of this view they claim that the size of the molecule is less than two millionths of a millimeter in diameter and if such is the case the particle is considerably smaller than the protein molecule. They further claim that they have been able to produce bacteriophage by incubating a dead culture of organisms in sterile broth. If this latter experiment is authentic, we would have to suppose either that spontaneous generation has taken place or that bacteriophage is not a living substance. Of course no one believes that spontaneous generation is a possibility under those conditions.

Every one of these theories has its advocates and every one has experimental evidence to support the particular view.

In the matter of therapy there are also several ideas. First, d'Herelle believes that bacteriophage is useful in therapy for the very good reason that the bacteriophage particles parasitize the pathogenic germs and destroy them, thereby permitting the patient to recover his health. He insists that bacteriophage must be alive and active else it will do no good. In our opinion this view is losing ground. A second idea is that the bacteriophage by being present in a wound causes the organisms to assume the "rough" instead of the "smooth" form. In the "rough" form bacteria are more subject to phagocytosis and less pathogenic. According to this view bacteriophage is of benefit because it compels the organisms to change to the less dangerous phase of their existence. Another view is that bacteriophage is merely a means of bringing about the lysis of the bacterial bodies thereby making the filtrate a rather strong solution of bacterial protein. Such bacterial protein makes a highly available and efficient antigen.

Besredka, for example, believes that the use of bacteriophage is merely one way—and an efficient way—of making an antivirus preparation. He describes his antivirus as having therapeutic qualities which are strongly reminiscent of the claims made for bacteriophage. It seems as a result of experiments that have been made by various authorities that the lysed bacterial antigen found in bacteriophage filtrates is efficient in the production of antibodies when injected and is also able to bring about to some degree at least local immunization of infected tissues. Various authorities have made the statement, for example, that bacteriophage is just as efficient in therapeutics after it has been heated to such a temperature as will destroy its lytic properties as it was before. If this is true the contention of d'Herelle that bacteriophage acts as a living parasite for bacteria is overthrown. Our personal opinion is that bacteriophage filtrate is virtuous in treatment because of the dissolved bacterial antigen which it contains. In other words the bacteriophage is merely an efficient method of making an antivirus preparation. Rather recently an article appeared in the Journal of the American Medical Association in which the commercial bacteriophage prepared by certain companies was sharply criticized on the grounds that the preparation as sold did not contain an active lytic principle. The criticism was made that the preparation contained 1-5000 solution of merthiolate and that the merthiolate had destroyed the life of the bacteriophage. We have ourselves made experiments and know of other experiments in which merthiolate was used without appreciable decrease in the activity of the bacteriophage, when it was properly stored and kept for a reasonable length of time. This contradicts the article to which we have just referred. Furthermore, we believe that even if the merthiolate should completely destroy the "life" of the bacteriophage, it would have little or more likely no effect upon the therapeutic value inasmuch as the therapeutic value probably depends upon the dissolved bacterial antigen rather than upon the lytic principle. The authors of the article to which we have referred evidently believe that bacteriophage works *in vivo* exactly as it does *in vitro*. This we very much doubt. We believe that the bacteriophage is merely one method of preparing a solution of bacterial protein and that the merthiolate is useful in such preparation because it insures its stability.

Concerning the value of bacteriophage our own experience is that it is of undoubted value in the treatment of staphylococcus infections when it can be applied locally and when the lysed organism is the same as or closely related to the strain that is causing the infection. Likewise we believe that it is of value under the same conditions in the treatment of Bacillus coli and streptococcus infections although these latter are not so accurate in their application. We have had no experience with other kinds of bacteriophage used in treatment.

COUNTY ORGANIZATION FOR DIPHTHERIA CONTROL

The Indiana State Medical Association for several years has set its approval upon the effort to eradicate diphtheria in the state. The means by which this should be done has not at any time been designated but has been left up to the discretion of the local physician and the county medical association. Different communities have used different means. Several counties, for example in the drought area of the southern part of Indiana, were able to immunize a considerable number of children under a plan whereby the Federal Government furnished the biological material and the physicians of the county donated their time for the immunization of those who were unable to pay. Conflicting reports have come as to the desirability of such a plan. Some communities and some physicians have reported that they were satisfied with the method, while others have raised considerable objection largely on the ground that it is not the function of the United States Government to assume responsibility for a relationship of this sort. Other counties have had other plans. For example, the Ripley County Medical Association submitted a proposal to the state organization and the chairman of the Diphtheria Prevention Committee, whereby the members proposed to look after the interests of the children of their own county, and as has always been the practice of the medical profession, take care of those who are unable to pay. The work must have represented a considerable effort on the part of the physicians of the county and they are to be highly commended. Ripley County has for several years had the unique distinction of having every physician in the county a member of the local medical society. The very fact that such is the case would lead us to expect that whatever they would do would be done in a highly ethical and thorough manner.

Recently we have had occasion to learn of the splendid plan which has been worked out in Carroll County. Last summer and fall the medical society of that county made itself informed by correspondence and lectures on the best method of diphtheria immunization. The medical association then proposed a plan whereby the children of the county could be immunized at a minimum expense to the parents and the least possible bother on the part of the profession. It is most commendable that every doctor in the county worked in harmony with the plan. Furthermore, every township trustee in the county was cooperative.

Before the attempt was made to go ahead with the project, lectures were given at the school buildings explaining the plan and the reason for immunization. Notice of the work was also given in the local newspaper. We have the assurance of the secretary of the Carroll County Medical Association that the public responded splendidly to the plan which was somewhat as follows: every child who could afford it was charged one dollar for the diphtheria immunization which was to be followed also with a Schick test and smallpox vaccination at a later date. Each trustee paid a certain small sum for the immunization of indigent children, the doctors of course largely donating their services in this case. It is reported to us that the Carroll County schools have about three thousand pupils in eighteen schools. Several of these had already of course been immunized previous to this campaign. In order to simplify the work somewhat, the children of some of the smaller schools were brought to larger centers so that there were only twelve places where the doctors needed to visit. Altogether 2,355 children, of whom 465 were of preschool age, were immunized. The trustees of the county expended a total amount of $340.00. At the end of the compaign each doctor in the county received a check for $87.00 and in addition to this there was a balance of $106.00, which was transferred to the Carroll County Medical Society treasury. We feel sure that we have never heard of a more carefully planned campaign or one that showed a finer degree of cooperation. Carroll County, we might also add, has 100% of its doctors in the medical society with dues paid for the year 1933. We believe that it is no accident that the two counties which have shown such forward methods should be 100% loyal to the ideals of organized medicine.

POPULAR MEDICAL EDUCATION

We attended a medical meeting a short time ago and were much struck by the fact that every one of the eight essayists and discussants mentioned the importance of education of the layman in regard to the subject which they were discussing clinically. A paper on cancer of the tongue pointed out that unless the layman by some means or another understands that he should go early to a family physician, there is little hope of improving mortality rates from cancer of this sort. The work of Bloodgood as a leader in cancer education for the public was mentioned both by the essayist and the discussant. Apparently there can be very little argument on this point inasmuch as early diagnosis is indispensible to the successful treatment of cancer and early diagnosis is absolutely impossible without the cooperation of the public. Obviously the layman must come to the doctor before the doctor can diagnose cancer since most cancers are painless in the early stages and it is not enough that the patient shall come to the doctor after he has definite cause for complaint—pain, soreness, tumor, etc.

Another subject for discussion this particular evening was the matter of hernias. It was pointed out that operations for non-strangulated hernias have an insignificant mortality while emergency operations for strangulated hernias carry a con-

siderable risk. It was stated that about three-fourths of all hernia operations are for strangulated hernias. Why should people wait until the hernia is strangulated and why should they meddle with the hernia in clumsy attempts to reduce it? Obviously the surgeon will rarely have the opportunity to do anything with a hernia in an unstrangulated condition unless the public is instructed in advance of the possibilities.

Another paper was on the subject of diphtheria prevention. Again both speakers emphasized the fact that we must sell this work to the layman. In order to immunize a child against diphtheria the consent and active approval of the parents must be obtained. We understand of course that there are those members of the profession who think that it is of no consequence that the patient should understand his condition. Prescriptions in Latin and diagnoses in enormously technical terms have been favored by these members of the profession. We must not forget, however, that it is the layman who pays the bill. It is the layman's permit that enables the operation to go ahead. It is the layman's body or his child's body that is being subjected to our operations. How can we blame him then for wanting to know what the matter may be and what the outcome may be. One would hardly expect him to take the automobile salesman's word concerning the performance of the car that he is planning to buy. It is perfectly true that he does not understand automotive engineering but he still reserves the right to lift up the hood and inquire about various technical points and to ascertain as well as he may whether the thing seems to be put together in a workman-like and efficient manner. It is our opinion that the most successful salesman is the one who has a good car to sell and makes clear to his prospective customer the manner in which it works. Much as we may regret the fact that laymen will no longer accept our statements as being infallible oracles, we feel that "those days are gone forever."

Popular education in medical subjects has become a necessity whether we like it or not. The question is no longer will we teach, but rather *what* will we teach. Our own personal judgment is that certain subject matter is highly suitable and that certain other subject matter is highly unsuitable for instruction of this sort. Fine hairsplitting details are not necessary. The newer theories concerning disease, nutrition, sanitation, hygiene, etc., are nearly sure to be revised in the next few years and the layman will soon come to distrust our science if he sees it change too much. An example of this is seen in the new faddy material which has come out with regard to foods. Actually this matter of food must be very simple or animals and ignorant people would not know how to nourish themselves as well as they do. After a great deal of thought on the subject we have come to the conclusion that every really essential point in the whole food propaganda can be put into the following sentence, which, if thoroughly understood, is all that a housewife absolutely needs to know about nutrition. "A balanced ration consists of an abundance, of a variety, of clean, wholesome foods, attractively prepared and served in such a manner as does not too greatly change them from their natural state." We defy a food faddist by applying recognized scientific principles to find fault with that sentence.

Recently we have been following a health column which says that tonsillectomies are all wrong and that tonsils should be destroyed only by electrocoagulation. We have no doubt that electrocoagulation may be of value in certain cases but certainly it is unnecessary to teach the public the technique of the operation. Parents need rather to know what some of the more common symptoms of diseased tonsils may be. They should know of the possibilities of rheumatism and heart disease and should then be told to go to their own family physician, talk the matter over with him and permit him to decide upon the type of operation to be done. After they have talked with him they still have a right to decide whether the operation shall be done or not. Their judgment as to how the operation should be done is of course utterly worthless.

READJUSTMENTS

Judging by the response that the report of the Committee on the Costs of Medical Care has aroused, it seems that we are in the midst of swift and eventful changes which in the end may cause us to abandon much of our traditional individualism.

We may have to join our potential forces in order to forefend our profession against the threatening encroachments of a great number of organizations who seem to think there is money in it, but justify their activities as being measures of relief from the high cost of medical care, for those with low salaries, and for the working classes.

In this social world there are, indeed, hopeful periods in which men weakly strive towards the ends of justice, but very soon it is seen that these ends turn out to be those of gain. The ideals that men profess are usually branded with the iron of futility. Those purposeful policies and larger undertakings, the outstanding movements that mar or mark the records of history, are soon dissipated and swallowed up in the dissolving currents of time. It is the myriads of undiscriminated and miscellaneous incidences that flow from all the varied activities in the lives of men that are the determining factors as to what the future is to reveal to us. These are the social elements and ferments gathering on the restless sea of life, forces that perhaps may result in some vast overthrow.

Social upheavals do not occur from sources over which men exercise control, nor do they bear the credentials of design nor the specifications of plan;

but, regardless of the high and mighty postulates of men, the old and sometimes deeply cherished things are pushed aside, eventually perish, and are forever lost; there is never any returning even to the good things of the past once they are passed. Change moves the hands of time and Chance unfolds the panorama of the future, altogether obscuring the efforts of man to impress himself into the picture.

Readjustments to changed environment are the methods men employ to fit themselves into new situations.

We are now confronted with the shifting scenes of a new drama in which readjustments are in order. There will be nothing very permanent about these readjustments, the future is not yet subject to the decrees of men. Good judgment and wise counsel to meet the exigencies of today will give us experience and wisdom to meet those of tomorrow.

In this world of change there are no periods of stasis; there is either progression or retrogression. We perhaps have leaned too long upon the staff of tradition and enjoyed a too comforting faith in the eternal permanence of things; we may also have esteemed too highly our individualism as one of those imperishable verities that is supposed to withstand the ravages of time and the rythmic march of events.

In many ways we have seen medicine advance in keeping with the advance in other fields of learning. Specialization has taken up the work of transforming medicine from a meaningless and unproductive art to that of science and the useful forms of knowledge. In this work very much has been accomplished already and the future is rich with promise.

In social and economic affairs we are not doing so well. Quite naturally, our attention has been wholly concentrated upon the work of evaluating the new knowledge that comes welling up to us from the vast fields of experimentation and research. Quite naturally, also, we have neglected those stern and practical matters that concern us in our social functions and our relations to economic conditions. In these affairs we speak with the small voice of the individual, not with the voice of one hundred and fifty thousand liberally educated men and women.

Deeply absorbed with our chosen work within the group we have passively allowed much of the broader functions of medicine to pass into the control of non-medical agencies and now find our last remaining stronghold daily encroached upon by many irresponsible organizations seeking new ways of profit.

The general practitioner especially faces the prospect of continually diminishing returns. The government relieves him of the soldiery; the clinics absorb many others; the hospitals, entering into contracts with industry, take thousands away that have employment; the white collars take out sickness insurance; the rich and well-to-do are referred to specialists. This leaves the indigent and the dickering trustee. But the general practitioner isn't complaining, he never does; it is his credo to seem prosperous. Nevertheless he is hard hit and often.

Our only hope seems to be in organization. The profession should control medicine, or as much of it as possible under the present circumstances. Organized from the top down, local control by the county society acting as a unit, let our indispensable service to mankind secure for us the distinction and authority that in justice and equity belongs to us.

WILLIAM T. GOTT, M. D.

The recent death of Dr. William T. Gott, of Crawfordsville, recalls his service of almost thirty-six years on the Indiana State Board of Medical Registration and Examination. He and Dr. William A. Spurgeon, of Muncie, were the survivors of the original Board appointed in 1897. Theirs was a service not often equaled in medical history; a service that was and is of inestimable value, not only to the medical profession, but to the citizenry of Indiana.

It was our very great privilege and pleasure to serve with these men for a period of some nine years, during which time we had frequent occasion to learn of the work they had done back in the pioneer days of the regulation of the practice of the healing arts by the state. Prior to 1897 there were no such regulations; about all that was necessary was to make a declaration before the county clerk, and from him receive a "license" to practice. From our secretarial experience in handling the licensure of drugless practitioners, under the 1927 amendment, we know somewhat of the prodigious task that confronted the first Board in Indiana.

Often have we heard these two men discuss those early days; the criticisms they received were sufficient to make the ordinary man seek a release from the obligations assumed; but these were not ordinary men—they had a duty to perform, had pledged themselves to carry out that duty, and proceeded to do so. That they did their work well is evidenced by the fact that seldom have the higher courts upset any of their rulings.

It is not generally known that the matter of inter-state reciprocity is chiefly of Indiana origin, and that these two men were probably the greatest factors in bringing about that scheme. The present Federation of State Boards, now a most important factor in regulation of practice, was the brain-child of these same two men. Dr. Spurgeon is still with us, and remains a most valuable man on the Board; but Dr. Gott is gone, and, with his passing, the profession of Indiana—yes, the people of Indiana—have lost a very dear friend. A large man, physically, he was possessed of a stentorian voice that often brought fear to the neophyte who did not know him. Yet Dr. Gott was the friend of the

young man seeking licensure. On many occasions we have heard him talking to young men, giving them a host of good advice, culled from a generous experience of many years in professional work. He was a stickler for the letter of the law and when, as not infrequently happened, the Board was importuned to make "just one little exception" for the licensing of some applicant who did not meet the requirements, Dr. Gott used no uncertain terms in making clear his position and that of the Board. In recent years he deeply regretted that infirmities prevented longer service as Secretary of the Board, and the meeting at which he tendered his resignation will long be remembered by those who were present.

Dr. Gott has gone; may his soul rest in peace—a peace so justly deserved through his work here on earth.

EDITORIAL NOTES

DEAR DOCTOR:

THE JOURNAL and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital.

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Perhaps you want a certain kind of instrument which is not advertised in THE JOURNAL, and do not know where to secure it; or do not know where to obtain some automobile supplies you need. This Service Bureau will give you the information.

Whenever possible, the goods will be advertised in our pages; but if they are not, we urge you to ask THE JOURNAL about them, or write direct to the Cooperative Medical Advertising Bureau, 535 N. Dearborn St., Chicago, Illinois.

We want THE JOURNAL to serve *you*.

FROM the Barter and Exchange column of the Fort Wayne *News-Sentinel*, glimmed by Dr. L. P. Harshman: "Set Books on Child Training; for Washer." Well, that's the height of something or other in these hectic times.

THAT there is no limit to what merchants will do now-days is evidenced by a full-page advertisement clipped from one of our Indiana newspapers and sent in by one of our members. It seems that one of the stores of that city was staging a going-out-of-business sale and prominently displayed in the center of the page is the statement—"Forced to quit—Doctor's Orders." It also includes what purports to be the letter from the doctor, in which this advice is given. Surely modern business overlooks no good bets.

LUNDY, in the *Illinois Medical Journal* for February, 1933, describes a case of argyria from colloidal silver. Many physicians have felt secure in the continued use of these preparations over a long period of time, but argyria from these preparations is by no means rare. In this case the patient used the original prescription for quite some time, then persuaded the druggist to dispense it in wholesale quantities; it was being used for the relief of a nasal condition, the particular drug being neo-silvol. Colloidal silver is commonly counter-prescribed by practically all druggists and our experience is that refills usually are to be had without question. It might be well to direct the attention of our druggist friends that a long-continued used of the colloidal silvers is not without danger.

THE passing of Dr. J. S. Van DerSlice, of Oak Park, Illinois, is a great loss to the Illinois State Medical Society and to organized medicine as well. "Van," as he liked his friends to call him, was of the he-man, go-getting type; a believer in the rank and file of the profession and with little regard for the various hyprocrisies that some few years ago seemed to be a great factor in our large medical societies. For more than ten years in the A. M. A. House of Delegates, he was there recognized for the marked abilities he possessed. In the two years that we attended the sessions of that House, we learned to have the greatest respect for "Van" as a thinking man, and one who had not the slightest hesitation in expressing his views. He will be sorely missed by his Illinois friends as well as the hosts of his friends outside of that state.

WHAT ABOUT YOUR DUES?

If you have not paid them, you do not have the protection of the Association's malpractice insurance. If you have delayed because of the bank holiday, SEND IN YOUR CHECK NOW. Checks for dues will be held until the banks open (such as have not already done so). The executive committee has authorized the headquarters office to receive checks; as soon as your check is received you are in good standing; your malpractice insurance protection is in force; your membership card will be issued. DON'T DELAY. PAY YOUR DUES NOW!

IN a discussion of "Precautions in Tonsil Operations," LaMott, in the *Delaware State Medical Journal* for February 1933, refers to his experience in the use of phenobarbital. He gives his adult patients from three to five grains, an hour before operation, using a local anesthetic of one percent novocaine solution. He states that the patient is much more comfortable during the operation, making the assertion that "it is possible to have practically every patient leave the operating room smiling." Any method that can accomplish this is cer-

tainly worth consideration. He attributes the good effects of the drug to its control of the cortical cells of the brain, thus calming the patient. By and large, this is one of the most readable articles on tonsil surgery we have read in years and the ensuing discussion brings out many valuable points.

The Journal is made possible because of the support of our advertisers; we could not publish The Journal did we depend entirely on the subscription price of two dollars per member. The Journal stands back of every statement made in every advertisement, hence you stand no chance of loss by patronizing our advertisers. And, it would be quite pleasing to The Journal staff if you would but mention that you "saw the advertisement in The Journal." By way of comment we may say that The Journal is one of the number that advertises none save "accepted" articles; in going over many of the exchanges we find too many of the state organs carrying advertising that would not for one moment be tolerated in our publication. Nor is this list confined to the smaller Journals; some of the greatest offenders are those published by states having the largest membership in their societies.

From the viewpoint of the humble, private citizen it would seem that our congressmen might unanimously support some program looking toward a prompt settlement of the great problems confronting us for the past few years; sidetracking purely political ideas would, we believe, meet with the approval of most of our citizens. Most of us feel that we have been in the doldrums long enough, and some of our representatives in Washington are going to be asked a lot of pertinent questions, once they get back to Indiana. It is all well and good to "stand" for something and to fight for that something on any and all occasions, but an admixture of a little common sense will often change the appearance of any question. Even a member of the Congress (and this applies to both Houses) can ride a fetish to its death, which ultimately means the death of one's political aspirations. A diagram will be unnecessary to those who have been following the recent doings of Congress.

Regardless of our political affiliations and beliefs we must take our hats off to President Roosevelt, in admiration of his moves to get things going. Drastic though some of his doings may seem, we must admit they have been productive of much good. The President says he has just got going, that he wants Congress to stay in Washington, without recess, until needed legislation has been completed. More power to him! That much has already been accomplished is evidenced by the fact that in what is probably the largest industrial center of Indiana there is now a feeling of buoyancy that has not been abroad for several years. Many of our industrial and business leaders, men who a few months ago were wearing the longest faces we have ever seen, have again learned to whistle as they go about the community. Prosperity, long advertised as being just around the corner, at last seems to assure us that it is really on the way back. CONFIDENCE is, just now, the most needed thing in America!

The present economic conditions are responsible for a spirit of unrest with many of our profession; not in many decades have there been so many changes of location; these, for the most part, being removals from the urban centers to the rural districts. In one of our larger cities we have had a half dozen or more leave for the smaller communities. Those from whom we have heard express themselves as being well pleased with the change, even though they do miss some of the comparative ease and comforts of a city practice. We have from time to time directed the attention of our readers to the "location" department maintained at headquarters office. Mr. Hendricks has devised a most excellent plan of listing various information regarding openings for physicians. This service is free to all our readers, as a matter of course and many have taken advantage of it. If you are interested in a change of location, if you know of a community that wants a physician, if you know of a physician looking for greener pastures, get in touch with headquarters.

A Congressional *lame duck* is one who, either by lack of activity or misguided effort, has lost the confidence of and has been rejected by his electorate but still continues to serve. Sinister, malevolent and foreboding are many of the panaceas being prescribed for this depression-weary world. Some of these are directed against the medical profession, and the time is here, right now, *today*, when every doctor should ask himself a number of questions, searching his innermost heart for honest answers. Am I a good doctor? Am I a credit to the profession to which I belong? Am I a worthy member of my county medical society? Do I attend regularly and pay my dues promptly? Do I strive there for unity of thought and action? Or am I a factor of discord? Am I constantly studying to improve my knowledge and thus render a better service? What is my attitude toward the public weal? Am I a good citizen in the community in which I live? In other words, and on the answers hangs the future of medical practice: Am I (or not) a *lame duck?*

Mr. Fred Crumpacker, an attorney, of Hammond, in talking to members of the Hammond Rotary Club, March fourteenth, expressed the opinion that medical care cannot be socialized or standardized. Some of his remarks, which we think

are timely inasmuch as they represent the views of a layman, are quoted herewith:

"It seems to me that some line of demarcation must be drawn in the socialistic tendencies of the time. I will agree that education now is socialized. I also will agree that police and fire protection are socialized.

"But I cannot conceive socialization of the healing arts; for, this is a profession essentially of individualism. Virtually all of the discoveries in medicine during the last few decades have been made by individuals and not by groups or clinics. They have made these discoveries and have given them to the world, not for the money they received, but for the honor and the prestige and the professional acknowledgment that comes with them.

"To socialize the healing art, would, in my opinion, deprive the medical world of advancement. It would standardize this profession, placing the accomplished and the mediocre in the same class. It would stifle individualism and individual effort.

"I believe in reforms, but I hold that reforms should be made in the abuses of the past. The medical profession is remarkably free of abuses. It should be permitted to develop unhampered along the lines of its glorious history of contemporary times."

THERE seems to be no closed season on various forms of solicitation, most of them in the name of sweet charity, and it occurs to us that physicians are the first to be put on the sucker list when an individual or a group plans one of the hi-jacking raids. Evidently the northern part of our state is not the only community in which these folks operate, as is evidenced by a special announcement sent to the membership of the Indianapolis Better Business Bureau. Tom Overly, its genial and very capable manager, surely "does himself proud" in this interesting bulletin, listing and carefully describing the *modus operandi* of some ten or more plans of getting easy money. Tickets to benefit balls; raffles of all sorts; bunco parties,—an endless list of schemes, the proceeds from which are "to go to the relief of some sorely distressed person or group," are abroad in the land and it behooves us to supervise our petty charities with care. If our city has a live Chamber of Commerce, with an alert vigilance committee, or if there is a Better Business Bureau in the community, the problem is easily solved, since but a 'phone call is necessary to establish the merit of the solicitation. One hesitates, in many instances, not caring to be listed as a tight-wad, yet one does not care to be played for a sucker.

Time, March 13th, has somewhat to say about the uses of sodium amytal as an antidote for strychnine poisoning, crediting three Indianapolis institutions for such discovery: the Indianapolis City Hospital, the Indiana University School of Medicine and the Lilly Laboratories. With the characteristic brevity of his publication the Medical Editor abstracts an article on this subject in a recent number of *The Journal* of the A. M. A., making a very readable story. It seems to be well established that strychnine and amytal are almost perfect physiological and therapeutic opposites, and that they are perfect antidotes for one another. It is recommended that amytal be used intravenously for this purpose. Strychnine poisoning is said to take a toll of more than 150 persons annually, not a few of these being children who find it in the family bathroom medicine closet. We commend the original article to our readers.

A RECENT report from our public library indicates that there is a step-up of more than forty per cent in the book turnover. And, at most any hour of the day or evening, the reading rooms are completely filled. The private rental libraries report an increased business, also. With the medical profession there is every evidence that they, too, are reading more. It has been noted in our society meetings that many men heretofore without much to say in the discussion of various papers now are giving a review of the latest medical literature. In our town, a manufacturing center, it is a common experience to meet men on the street, on their way home from the library, carrying from two to six or more books. And, when we have had opportunity to glance over the titles, we are interested to note that fiction and other light reading appears but seldom. In the earlier days of unemployment many were content to "go down town and stand around," but now this diversion seems to have lost its interest, and a more general program of reading has taken its place. Perhaps a depression has some advantages!

WELL, the cross word puzzle seems to have met its Waterloo, though it surely did have its adherents for a considerable period. Now, so it would seem, the jig-saw has taken precedence over most all other forms of diversion. And, we are very frank to admit, it has attracted our interest to no little degree. It seems that many members of our profession have taken advantage of the present craze and have used it to good purpose in certain of their cases. One man reports very favorably as to the use of these puzzles by those who have had a partial paralysis of the arms and hands. Another urges his arthritic patients, those in whom the hands have become more or less crippled, to spend several hours daily with this amusement. He avers that there has been a marked improvement in more than one of these cases.

WELL, it looks as though we were to have our "likker," and that right soon. Within twenty-four hours after the papers carried the story that Governor McNutt had signed the law, we were being

importuned by no less than four salespersons, one of them a woman, immediately to get set for the big party; to get our alcohol permits refurbished or, having none, to make application for a permit. We will admit that the colored pictures of "the goods" were works of art, and the literature describing the various products well written; and that the sales agents, especially the woman, were well versed in their sales art. Now that this thing has been settled, so far as Indiana physicians are concerned, what will we do about it? What, if anything, can the Association do to safeguard the reputation of the profession? It should be remembered that not so long ago an officer of the Indiana Anti-Saloon League was quoted as saying that such a law as has just been enacted would serve only to increase the number of bootleggers in Indiana, specifically referring to the physicians and the druggists. We should not forget that not all our members are favorable to the prescribing of liquor by the profession, one society having unanimously voted to have nothing to do with such things as government liquor prescription books. Certain it is that we will be subject to the enquiring eyes of many folks who have been predicting dire things did the Indiana legislature make bold to annul the Wright Bone-Dry Law. On the other hand there are many of our members who will find no little satisfaction in having this law upset; they have rebelled at what they term an interference with the professional liberties of those licensed to practice the healing art within our state. Well, we shall see what we shall see, and it is to be hoped that another year will have proved unfounded the fears of our friends.

We have been looking over reprints for a good many years but only recently did we receive the last word in this commodity. The author, said to be connected with an Illinois charitable institution, apparently wants the world to know that he is in business and knows his stuff. Also, that his readers may know something as to the appearance of the author, he has used his picture on the inside front cover page. We do not recall an instance in which an essayist has heretofore printed his picture in his reprints. Another interesting thing about this reprint is the fact that it seems to have been pretty generally broadcast throughout that part of Indiana adjacent to Chicago. This fact, together with some statements in the opening pages, would seem to indicate that the mailing of this interesting article was done not entirely with altruistic ideas; in fact, we have a well defined notion that the author expects to reap a considerable harvest from his broadcasting. In his opening statements he stresses, several times, the fact that the operation in question, "Electrocoagulation of Tonsils," has not its just repute because it is being done by so many incompetents, that its success depends on expert handling of the patient; then he proceeds to qualify as such an expert. Regardless of the importance of the message contained in the reprint, the standing of the author, or the skill he has developed in this particular field, the fact remains that he seems to be doing a bit of first class advertising. The author in question announces himself as "——— ——— ———, M. D., University of Illinois, Medical Department, 1910; Associate Ear Surgeon, Illinois Eye and Ear Infirmary; Member Chicago Medical Society, Illinois Medical Society; Interne, North Chicago Hospital, Illinois Eye and Ear Infirmary; World War Service; Embarkation Hospital No. 2, Secaucus, New Jersey, U. S. Hospital Ship O'Reilly; Formerly Capt. Medical Reserve Corps, U. S. Army."

You can not practice medicine with the mathematician's slide rule; be human.... Verbal filibustering on the problems of Cost of Medical Care and Medical Relief for the Indigent merely delays the time when the profession, *itself*, must get down to brass tacks with an acceptable solution....The medical profession, by refusing to tie up with communistic schemes during the present emergency, will avoid costly alimony in the future inevitable divorce.... Doctors may be poor financiers, but they did not "fold their tents like Arabs and as silently steal away" as did one out of every six banks in the U. S. A. during the past three years.... It has been questioned why the five-and-ten cent stores do not carry a line of stocks and bonds; Indiana doctors need watch their steps that the policies which shipwrecked the stock market do not torpedo the medical profession.... Architects draw lines and engineers erect structures with mathematical precision, and yet there is no talk of socializing their services; how, then, can paternalistic communism be adapted to the practice of medicine, an art which deals in a very intimate and personal way with human variants of wide degree.... Eighty different skins are used in the U. S. A. in the manufacture of fur garments and trimmings; eight hundred and eighty different skin games are being tried on Indiana doctors, and the greatest of these is the attempt to foist upon the profession the principle that an intermediary is needed to contact the patient and his physician.... It is reported from the West Coast that Hollywood has gone baby crazy, that cod liver oil, tomato juice, and coddled eggs are prime topics of feminine social conversation, and that babies' unmentionables sway in breezes where once pink chiffon scanties only flapped; Indiana doctors, long since steeped in appreciation of the value of plain and simple living, soon will believe that, after all, some good may come out of Hollywood.

The number of persons per physician in the United States is 780, in Switzerland 1,250, in England 1,500, in Belgium 1,850 (just to mention a few), which leads to the deduction that adequate correlation of the medical service in this country

might well be undertaken toward the end that no community, however large or small, need complain of a lack of adequate medical care. It might be questioned otherwise, should the profession take no hand in this problem, whether or not we are approaching a state of affairs which existed in the first century A. D. when medical practitioners were in such excess that many of them were willing to officiate as gladiators in the public arena. It would appear, perhaps, that the smaller communities have been somewhat neglected in this regard, and there is no question but that many opportunities exist for the alert and aggressive type of individual. A physician practicing in the smaller community should be as well trained, at least, as his city colleague; in many respects, he should be better trained; because, singlehanded, he must meet conditions as they are presented to him without the aid of ready consultants, laboratories, and other facilities. While it is true that individual medical schools in a more or less passive way do what they can to satisfy inquiries from their graduates for openings in medical practice, yet there seems to be a singular lack of organized effort on their part to influence this distribution. It is highly uneconomical and inefficient that the present correlation of physicians with community needs depends so largely on the chance personal contact of medical students and internes with their physician friends in the medical profession. It would appear that administrators of medical schools could be of great service to their own students and graduates and to the different communities of their respective states if they would familiarize themselves with the opportunities for, and needs of, medical practitioners. The field is almost wide open in this respect for: (a) The Indiana University School of Medicine; (b) The Indiana State Medical Association Headquarters Office; and, (c) The Journal.

The last campaign included many features that may well be forgotten. While time will sift out even more of the chaff some grain has already been gleaned in the researches stimulated by the mention of the Forgotten Man. In a lecture delivered in 1883 by William Graham Sumner, Professor of the Science of Society at Yale, the plight in which the physician of the present day finds himself was accurately described. The recent recommendations of the majority of the Committee on the Costs of Medical Care have so faithfully followed in 1932 just what Professor Sumner condemned as unjust in 1883, that his views become worth reciting:

"The type and formula of most schemes of philanthropy or humanitarianism is this: A and B put their heads together to decide what C shall be made to do for D. The radical vice of all these schemes is that C is not allowed a voice in the matter, and his position, character and interests, as well as the ultimate effect on society through C's interests, are entirely overlooked. I call C the Forgotten Man. * * * He is the simple, honest laborer, ready to earn his living by productive work. We pass him by because he is independent, self-supporting and asks no favors. He does not appeal to the emotions or excite the sentiments. * * * He is always forgotten by sentimentalists, philanthropists, reformers, enthusiasts and every speculator in sociology, political economy or political science. * * * If any student of social science comes to appreciate the case of the Forgotten Man, he will become an unflinching advocate of strict scientific thinking in sociology, and a hard-headed skeptic as regards any scheme of social amelioration. He will always want to know, Who and where is the Forgotten Man in this case, who will have to pay for it all?"

It becomes the plain duty of the physicians of America to educate the public to the fact that it is they who are to pay for the schemes which A and B have decided to work off on C.

Legally, in America, the practice of medicine is restricted to those institutions which are recognized by various State Boards for the purpose of medical licensure. It is but dimly understood by the laity that the intent of this restriction is not particularly to create superbenefits to the individual doctor; but, rather, it is a sociological circumstance fostered by and accepted by the profession as a vital protection of the public weal. The situation carries with it grave responsibility on the part of the medical profession in its attitude to the quality and training of the younger physicians. In the first place, it may be stated as a truism that a medical training which over-accentuates the dependence of the doctor upon hospitals, laboratories, technicians, nurses, consultants, and specialists handicaps the beginner in practice in assuming an individual responsibility which he should not hesitate to accept. Again, there should be no misleading over-emphasis upon rare and unusual diseases which might tend to favor neglect in thorough preparation in handling those types of illness which are so prominent in every day practice. Still further, medical teachers who know little or nothing at first hand of actual, private, competitive practice, have difficulty in transmitting that philosophy of idealism to students attending their lectures. The way we train and locate our young men just beginning practice, and the manner in which we bring them into the fold of organized medicine, will have a tremendous bearing on our future medical opportunities. Finally, the continued education of a physician, if he expects to be scientifically successful, throughout his entire professional life, is synonymous with good medical practice; organized medicine must provide the facilities whereby every physician who wishes to do so may carry on in this regard, to the best of his individual capacity. It is not enough that one, two, or three, in each county society continue in this post graduate effort, because the degree in which medicine takes its proper place in

modern society depends not upon the professional leadership of a few, but rather it is most intimately bound with the extent to which the rank and file can keep abreast of an ever increasing medical knowledge. In a large part, the program for post graduate instruction, in so far as it is practical, should be carried to the practicing physician in his community.

H. L. Mencken in his *American Mercury* has nearly always been fair in his discussions of the medical profession. His editorial on the report of the Committee on the Costs of Medical Care, in the March issue of his magazine, deserves to be read by the profession. It is a layman's expression of his reaction to the Report but it cannot be classed as an ordinary lay opinion, for Mr. Mencken has always had too intelligent a viewpoint of scientific matters to be classed as ordinary. The following are quoted excerpts from his discussion:

"A substantial part of the increased cost, of course, is due to improvements in the art of medicine. Not a few of them call for expensive apparatus, and all of them call for kinds of skill that cannot be had for nothing."

"And it is plainly more expensive to cut out a gangrenous appendix and nurse the patient back to health than it used to be to give him a dose of Glauber's salts and send for a clergyman."

"I do not believe that the doctors, taking one with another, have profited to any considerable extent by the vast increase in the cost of medical care. The average income among them is probably not much more today than it was twenty years ago; if it has grown at all, then it is only to the extent that other professional incomes have grown. The general practitioner, indeed, is probably worse off today than he was then. Nor has most of the excess gone to the specialists. *It has gone to the hospitals, and they have got it, not in the character of institutions for the care and cure of the sick, but in the character of luxurious hotels for the entertainment and flattery of the sick.*"

"Their chief postulate seems to be that it is the bounden duty of the state to take care of every citizen who can't or won't take care of himself, and they are always eager to pour out the taxpayer's money to that end. But there is really no such duty. The really helpless and friendless sick, of course, must be cared for, if only to keep them from shocking the well by lying in the gutters, but the public responsibility does not go half so far beyond that simple business as uplifters appear to think."

"The dubious doctrine that what ought to be done must be done has been converted into the even more dubious doctrine that what ought to be done must be done free, and as a result great multitudes of Americans, hitherto willing enough to pay their way, have been converted into mendicants, and a large part of the burden of their mendicancy has been thrown upon the medical profession."

"Charity is not a franchise; it is only a favor properly offered to the really helpless, and to no one else. It may impose upon the benefactor something that he chooses to regard as a duty, but it certainly gives no vested right to the beneficiary."

"Thus the doctors are beset by uplifters on the one side, as they are beset by quacks on the other, and it is no wonder that they begin to be concerned about the future of their trade."

"But then the health department of his town began to go into the medicine business, and in a few years his practice was as good as ruined. Half a dozen free dispensaries of one sort or another were opened in his bailiwick, and nurses on the city payroll began to rove the streets in municipal Fords, seeking prospects."

"He delivered babies at $20 a head, and took in enough at the business to pay his rent. But now the city nurses began pouncing on his patients at the first sign of divine retribution, and by the time those patients came to term they were installed luxuriously in some tax-supported maternity hospital, and having the time of their lives. My friend, of course, could not remonstrate with them, but it was at least ethical for him to make some discreet inquiries. 'The nurse told me,' he was commonly informed, 'That I could get a professor to help me—and it wouldn't cost a cent'."

"The doctors have let the public health and public schools schemers run away with them. They should have resisted this movement vigorously, as the lawyers in like case would have certainly resisted it, but in only too many American communities they have helped it on, thus acquiescing idiotically in their own destruction."

"The limits of prevention are fixed by Nature, and within the limits of private practice they are plain enough, but when a medical man succumbs to uplifters and begins to rove the wide pastures of Utopia he sometimes loses all contact with fact, and begins to talk as foolishly as the uplifters themselves."

"If on the one side, they will unite in a genuine effort to throw off the uplifters who now victimize them, and on the other side try to rid their customers of the grotesque idea that being ill is a romantic business, and an excuse for the indulgence of levantine luxury and the waste of a great deal of money, most of it not in hand—if they will proceed realistically in both of those directions they may conceivably throw off some of the difficulties which now beset them."

"They are actually, with very few exceptions, fellows of a vast and innocent sentimentality."

"They walk into the arms of every new uplifter who happens down the road. My hope is that the report of the Committee on the Costs of Medical Care, with its bald proposals to reduce them to a kind of peonage, will at last awaken them to the fact that they also owe some duties to themselves, and that, with everything else equal, the more they regard those duties the better they will be able to serve their actual patients."

THE PRESIDENT'S PAGE

Events are so rapid and revolutionary today, one wonders what may confront one each morning. We of the medical profession are not alone in our troubles, and may take some comfort from the fact that the muck-rakers and reformers are busy with so many problems that we come in for only a small part of the publicity.

The group selected to continue the work of the Committee on the Cost of Medical Care put out some propaganda a short time ago in the form of a syndicated editorial, attempting to lead people to believe that the Committee was releasing some new information. It was simply a rehashing of what had already been made public, but its form was intended to convey the impression that the article contained additional information. The six hundred page book of which it spoke was the complete report from which was abstracted the two hundred page report released in December, and the study of the 9,000 families was the study made in 1928-1931 by the Metropolitan Life Insurance Company.

The legislature has adjourned. Some of us feel deeply grateful and happy; others resentful and disappointed at much that it did. Let us not judge its acts too hastily. No matter what our party affiliations are, we are first citizens of the state, and our duty is to support state laws. Then if, after due trial, we feel them wrong, our opportunity comes to prepare for a change at the next election.

Just what the new tax law means to us as physicians can only be told after trial. If our total tax bill is lowered, well and good.

The repeal of the Wright bone dry law, I believe, is hailed by the large majority of physicians as being most desirable. Not many will actually feel the need of liquor in their business, but the principle of restricting the physician in his choice of remedies was basically wrong, and could lead to far greater restrictions should some fanatics develop brain storms, and create enough followers.

The work of Tom Hendricks in the House deserves praise from the whole membership. His vote on some individual, non-professional, measures may not have pleased some, but he was in the assembly to represent the medical profession, and his work in their behalf and for their protection outshadows all other acts he may have performed as an assemblyman. No one could have worked harder, nor done more for the profession than he. Our loyalty demands that we not let our political partisanship make us critical of decisions on matters not intimately concerned with the medical profession.

I want to urge the necessity of having more doctors in our next legislature. There is no reason why we should not have a dozen or more in the assembly of 1935. The unfortunate illness of Dr. Miller kept him at home this year. He would have been a strong figure in the Senate, and he was greatly missed.

The Legislative Committee functioned all of the time, and was a great help to Tom.

Unfortunately, through channels entirely beyond the control of anyone, the chiropractic bill was twice forced out upon the floor of the senate over the recommendations of the committee. This goes to prove the political strength of the chiropractors, and is a warning to us of the necessity for being prepared for future battles.

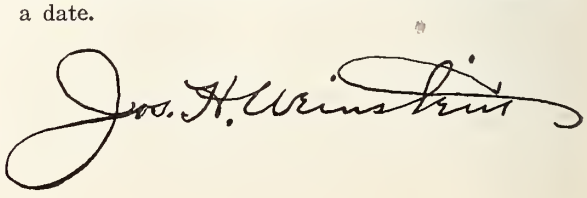
We have reason to believe that Governor McNutt will be pleased to confer with the Association in regard to medical appointments and the re-organization of medical departments. The Association does not ask that it designate appointees, but only that appointees be members of the Association in good standing, and be qualified efficiently to fill their positions.

The banking situation has handicapped the Association somewhat. The large part of our receipts were all in by March first. The membership has fallen off slightly, and I appeal to all members who have not paid their dues to do so at once. Also to all secretaries to make a special effort to collect dues and send them in promptly.

Last month I warned the members of the increased number of malpractice suits. Again I call this to your attention, as well as the fact that your membership card for 1933 is the cheapest and most complete protection you can have. Now more than at any time in many years past is this so.

I urge you to give the Committee on Puerperal Mortality all the information possible. This Committee will soon send out a questionnaire to each member. Do not throw this aside for future answering. Take some of your time as soon as it is received, and answer to the best of your ability all questions asked. This Committee is earnestly endeavoring to get at the true picture in Indiana. It is your duty to help them.

The Flying Squadron is busy. It has attended meetings at Frankfort, Greenfield, Muncie, Crawfordsville and Noblesville, and is scheduled for Spencer, Richmond, Marion, Kingman, New Albany, Columbus and French Lick. Write Tom for a date.



MEDICO-LEGAL DEPARTMENT

By
Albert Stump,
Attorney for the Indiana State Medical Association

QUESTION: How does the gross income tax law affect the income of physicians and surgeons?

ANSWER: The Gross Income Tax Act of 1933 levies a tax upon gross incomes of all kinds at the rates fixed in the act. That part fixing the rate at which physicians' and surgeons' incomes would be taxed includes "the gross income from professional services, personal services, sales of real estate, all funds received for the performance of contracts, all funds from the investment of capital, and all receipts from any source whatsoever," of certain classes of incomes as classified in the act, and fixes the rate at one per cent.

The term "gross income" is defined as meaning "the gross receipts of the taxpayer received as compensation for personal services, and the gross receipts of the taxpayer derived from trades, businesses or commerce, and the value proceeding or accruing from the sale of property, tangible or intangible, real or personal, or service, or any or all of the foregoing, and all receipts, actual or accrued, by reason of the investment of capital, including interest, discount, rentals, royalties, fees, commissions or other emoluments, however designated, and without any deductions on account of the costs of property sold, the cost of materials used, labor cost, interest or discount paid, or any other expense whatsoever, and without any deductions on account of losses."

If you have any questions to ask about any phase of this subject, address your inquiry to the headquarters office, 1021 Hume Mansur Building, Indianapolis.

Upon the foregoing definition of what shall constitute gross income as the term is used in the Act, it is my opinion that the physician and surgeon would be required to pay a gross income tax of one per cent on all fees charged, including the funds collected by him for the cost of medicines used if he dispenses the medicine himself. The expression above quoted, "without any deductions on account of losses," in my opinion refers to losses that might be sustained through any causes whatever connected with his profession or business. But it does not mean losses of potential income through the failure to collect accounts. *The income is to be levied upon the actual receipts.* And the total amount of the actual receipts, and not the total amount of what may be on the books, is the basis of the computation of the gross income tax. One might sustain losses on account of the deterioration of supplies and equipment, or through automobile accidents, or fire, or other such incidents, and that class of losses could not be deducted. The failure to collect an account, however, is not strictly a loss as the term is used in this Act, for in that event there never had been a realization of any compensation which could be lost. The account, until it is collected, would stand as a mere possibility of an item of income which would be realized and taxable only as of the time when it was collected.

The Act contains an emergency clause by which it is made to take effect on the first day of May, 1933. Reports are required to be made "on or before the 15th day of January, April, July and October in each year for the period ending on the last day of the preceding month." The first report therefore would be due on July 15th and would cover the gross income for the months of May and June, 1933. These reports are to be made on forms to be supplied from the office of the Department of Treasury of the State.

It is the duty of every person subject to taxation under this Act to keep such books and records as may be necessary to determine the amount of his gross income and the taxes for which he is liable. These records are required under the law to be preserved for a period of two years and are open for examination by the Department of Treasury of the State or its agents.

Intangibles Tax

QUESTION: What is the new law concerning the taxation of intangibles?

ANSWER: Intangibles are defined in the new Act concerning their taxation to mean the following:

Promissory notes;
Stocks in foreign corporations;
Bonds and debentures;
Final judgments;
Certificates or other evidences of indebtedness except of certificates of deposit in any bank or trust company of the State;
Brokerage, trading accounts, accounts arising out of transactions involving deposits or loans of money, except deposits in banks or trust companies in Indiana;
Corporate securities including instruments with interest coupons and evidencing a debt;
Mortgages, chattel mortgages, bills of sale, or other written instruments evidencing or securing a debt;
Written contracts for the payment of money, excepting contracts for personal services or for manufacturing or processing merchandise, and excepting executory contracts for the sale of merchandise;
Certificates or other instruments evidencing an interest in property for the benefit of the holder of such certificates or instruments.

All the foregoing items are listed as being included in the term "intangible".

The following the Act lists as not being included:

Intangible property having actual business situs outside the State;

Banker's acceptances, bank checks, drafts, deposits in bank and trust companies or certificates representing the same, in the State;

Obligations or other intangibles owned by any bank, trust company, building and loan association, rural loan and savings association, insurance company or association, either foreign or domestic;

Shares of stock in any national bank;

Shares of stock in any bank, building and loan association, rural loan and savings association, nor guaranty loan and savings association;

Shares of stock of any corporation organized under the laws of this State;

Life, health or accident insurance policies;

Awards for workmen's compensation;

Judgments or allowances for support;

Judgments for alimony of less than $1,000.00;

Obligations of the State or any taxing unit of the State expressly exempted from taxation by the laws of the State;

Obligations exempted from State taxation by laws of the United States.

Intangibles are classified as "current intangibles" and "annual intangibles," the current intangibles being those that mature within one year of the date they are made or within one year of the date of the taking effect of the Act, and all others being annual intangibles.

The Act levies a tax on all intangibles owned or controlled by a resident of the State of Indiana, "except his intangibles having an actual business situs outside the State of Indiana." The meaning of this quoted part is rather obscure, but it probably will be construed to mean intangibles acquired and used in the course of a business that is carried on outside the state and which are never actually delivered to the resident within the state.

The amount of the tax is five cents on each twenty dollars or fractional part thereof, of the actual value of every current intangible; and "five cents per annum or frational part thereof, over one year on each twenty dollars of the actual value or fractional part thereof of each annual intangible." This provision in regard to annual intangibles I assume will be construed to mean five cents on each twenty dollars of value is to be paid each year as long as the intangible remains in effect, with the proper provision for the fractional part of the year and of the fractional part of the twenty dollars.

The owner of an intangible may have the actual value determined for the purpose of computing the tax by applying to the State Tax Commissioner or County Assessor for the valuation, which shall be determined thereafter in a hearing at a time and place fixed by the assessing officer. If one is dissatisfied by the value that is fixed by the County Assessor he has a right to appeal to the State Tax Commissioner, who conducts a hearing and fixes a value. If dissatisfied with this value an appeal is permitted to the Circuit Court of the county in which the owner resides, and appeals may be taken to the Appellate and Supreme Courts from the Circuit Court.

The tax is paid by attaching stamps for the proper amount on each intangible. The stamps must be attached within ten days from the time of the execution of all current intangibles, and if the current intangible is not discharged at the date of maturity or one year from the date of its execution it is then treated as an annual intangible and must be stamped each year. Annual intangibles are to be stamped within ten days from the date of execution and thereafter to be stamped on or before ten days "after each annual anniversary of such annual intangible" until it is discharged. Where the intangible matures on or before ten days from the date of execution the stamps are to be attached at the time and as a part of the execution. Intangibles executed before the taking of effect of the Act and maturing within ten days after the taking effect of the Act are to be stamped before the discharge of the intangible. Those intangibles which were executed before the Act took effect are deemed to have been executed on the day the Act becomes effective and to be either current or annual intangibles as determined by the time thereafter of maturity. All intangibles shall be stamped on or before the intangible is paid or discharged, and if not paid or discharged before ninety days after taking effect of the Act, then they shall all be stamped within the ninety day period. The anniversary date of prior existing intangibles is determined by the date the Act becomes effective.

Where the intangible is of such a nature that it cannot be stamped or is not evidenced by an instrument in writing, the owner is required to file with the State Tax Commissioner a sworn report of the amount, description, and location of such intangibles on forms submitted by the Commission, who thereupon determines the amount of tax due and whether the intangibles are current or annual. The owner of such intangibles pays the tax upon the value determined by the Commission. Within ten days after each 31st day of December a report covering intangibles of this class is to be filed by owners with the State Tax Commission. The first report is to be filed within sixty days after the Act became effective.

Penalty Is Heavy

Owners of annual intangibles may register them in the office of the Tax Commission and then pay the tax due without the use of stamps and receive the receipt from the Commission for such payment.

Any tax on intangibles if not paid when due is entered upon the tax duplicate and becomes a lien on the property of the taxpayer, in the same

manner in which omitted property is entered. The failure to pay the intangible tax subjects the owner to a penalty of four times the amount of the current tax, and all unpaid taxes and penalties draw interest at the rate of ten per cent. per annum.

One receiving into his possession intangibles upon which the tax is imposed should examine the intangibles to determine whether they have been properly stamped and the tax paid, and no one is permitted to authenticate a signature or acknowledge an assignment of such intangibles unless the stamps or certificates showing payment for the current year accompany the intangible.

The stamps referred to are obtainable in the office of the Treasurer of each County and at such other places as the Commission may deem necessary. When a stamp is used the person affixing it shall write or stamp thereon his initials and the date when it is affixed and mutilate the stamp so it cannot be used again.

No instrument can be recorded on which intangible taxes should be paid which do not bear the proper stamps, nor is any sale, transfer or renewal of any such intangible valid, nor can the intangible itself be enforced unless and until all taxes and penalties have been paid.

No other tax than this intangible tax is levied upon intangibles, except of course that estate or inheritance taxes are payable from intangible assets the same as from tangible. No law regarding the listing and assessment of omitted property for any time prior to the taking effect of this Act applies to intangibles on which the tax is paid in accordance with the intangible tax law. That is, all former taxes that may not have been paid on intangibles by failure to list them are wiped out by the proper listing and payment of the taxes provided for in this Act. The Act contains the provision that there may be an extension of time not to exceed ninety days for the payment of intangible taxes. All penalties are suspended during the time that the stamps are not available, and if one having such intangibles desires to sell or transfer he may pay the tax to the County Treasurer and attach a receipt therefor to such intangibles.

There is a penalty for authenticating, or issuing, or accepting any intangible or making any assignment or transfer thereof without the tax being paid and the stamps affixed, and for the failure of cancelling the stamps used, the penalty being a fine of not less than twenty-five dollars or imprisonment of not less than thirty days or both. The violation of this provision is a misdemeanor. The forgery or use of stamps a second time is made a felony, punishable by a fine of not less than one hundred dollars or imprisonment of not less than one year, or both.

The Act contains an emergency provision which makes it effective and in full force from and after its passage. The date upon which the Act took effect was March 1, 1933.

REPORT OF LEGISLATIVE COMMITTEE

Never in modern Indiana history has so much been done at a single session of the legislature that so affects the members of the medical profession both as citizens and as doctors as at the session just closed. Jammed into sixty-one anxious days was enough activity both for and against measures vitally important to every doctor in the state that it kept the officers and legislative committee of the Indiana State Medical Association on guard every minute of the time. No attempt will be made in this report to give more than a brief summary of those measures passed and signed by the Governor and list all those measures introduced during the session that either directly or indirectly would have affected the members of the medical profession had they become laws.

The session itself was of such unusual nature and the group promoting the program of the administration was so well organized that work on the floor of the House and Senate against any administrative measures got nowhere. Any really effective move, therefore, usually had to be taken before measures came to the floor or by contact with the leaders of either branch of the assembly. It is only fair to say that on every occasion that any member of your committee had to present the side of the medical profession in any matter, he was received with courtesy and friendliness. Of course many measures in which the profession was interested came up for consideration before the public health committees of both the Senate and House, whose members without exception displayed an intelligent conception of the facts, a grasp of the situation and a deep desire to act in the interest of the public.

Although a number of side issues and innumerable skirmishes took place, so far as the medical profession was concerned, the session may be divided into three major battles: the first, the cult battle; the second, against those who wanted to tax the physician and limit the fee he should charge for prescribing medicinal whisky; and the third, the tax battle.

Cult Battle

As so many new members were present in both the Senate and House, and as the cultists had distributed much propaganda, both by pamphlet and personal conversation, telling how the present law and the medical board discriminated against the chiropractors, your state committee was faced with the task of getting the side of scientific medicine and the necessity for uniform standards of education for those who treat the sick before the legislators. It developed that many of the members of the general assembly had gained the conception that the medical profession was a closed corporation and a "trust" which was keeping com-

peting practitioners from other schools of healing out of Indiana merely for selfish reasons.

Fight in House. Several of the members of the public health committee in the House were convinced this was a fact until the entire truth of the situation was explained to them, most effectively in the majority of cases by their own family physician. Nevertheless when the public hearing was called, things looked a bit uncertain. But if things looked uncertain before the hearing, when the spokesman for the chiropractors had completed a most impressive presentation of his side of the case, it was doubly uncertain as to how a group of laymen, such as largely made up the public health committee in the House, would react. Whatever their sentiments and predilections may have been when they came to Indianapolis, and no matter how good a speaker the chiropractors had to advocate their cause, the committee reported the bill out with a unanimous recommendation for indefinite postponement because of the following reasons:

(1) The committee did not desire to create another state board.

(2) The committee did not feel that a chiropractor should be empowered by law to do more than manipulate the spine.

(3) The committee did not feel that the chiropractors should be allowed to do minor surgery (as they would have been allowed under the bill).

(4) The committee did not want to give the chiropractors preferential rights over a regularly licensed physician before the compensation board.

(5) The committee was not at all certain that chiropractors should be allowed to enter hospitals and state institutions on the same basis as a physician.

The committee report was adopted by a voice vote in the House. But the trouble was far from over. Scarcely had the original chiropractic bill been killed than a bill that would strike out the injunction clause in the medical practice act and would leave the act without teeth was introduced. This was reported out of committee for indefinite postponement and was killed by a voice vote on the floor of the House.

Fight in Senate. In the meantime, the cultists turned their attention to the Senate and after several strenuous weeks finally were able to get three senators to introduce their bill, which was very similar in nature to the one introduced in the House, only a few days before the time limit for the introduction of bills took effect. The committee in the Senate held a hearing on the bill which was attended by a dozen or more physicians selected by your committee to represent the profession and at which Albert Stump, attorney for the Association, was the only spokesman. No chiropractors were present and none of the authors of the bill put in an appearance.

Following along the same line of reason as did the House health committee, the Senate committee reported the bill out for indefinite postponement. This recommendation was adopted and it looked as if the cult bills were all dead for the session. Not so, however, as late one afternoon, just before adjournment, the Senate reconsidered its action and moved the bill on to second reading. A great deal of mystery as to causes, intents, and purposes shrouded this move as far as your state legislative committee could discern, but at any rate the bill rested there the last ten days of the session and never was called down for third reading.

Throughout the battle in the Senate the medical profession was very much hampered in its action against this bill due to the fact that Dr. George Miller, of Logansport, Senator from Cass County, was ill most of the session, and the entire burden of the fight in the upper house fell upon the capable shoulders of Dr. Isaac Trent, of Muncie, Senator from Delaware County. He was most effective, and had he and Dr. Miller both been on the floor together, it is doubtful whether the bill ever could have been brought up for reconsideration in the Senate. Your committee sincerely hopes Senator Miller will be his old fighting self next session and will be on hand with Senator Trent.

Medicinal Whisky

Besides carrying out the repeal of the Wright bone-dry law which prohibited physicians from prescribing whisky, your committee had no further interest in liquor legislation. However, the beer bill carried several sections regulating the powers of physicians in handling medicinal whisky, and so your committee had to watch the progress of this bill very carefully to see that nothing unfair or unjust to the physicians was written into this measure. As originally introduced the bill contained one item which was very objectionable to the profession—a limit of $1.00 which physicians were allowed to charge for prescriptions. It wasn't the fact that they were limited to a $1.00 prescription fee that particularly concerned the committee as much as the fact that the General Assembly of Indiana should place any limit on any fee that a physician might charge for any prescription. That would be the entering wedge of state regulation of fees—a start in state medicine! So after various conferences with the authors of the bill and those in high places, your committee finally gained their consent to take off the prescription limitation fee.

As the bill passed the House and went over to the Senate, it seemed harmless enough as far as the medical profession was concerned, but somehow, someway, when the bill passed the Senate a 50 cent tax per pint was attached *to be paid by the physician!* This came about as the distillers, wholesalers and retailers were all battling as to who should pay the state tax and they finally decided on a compromise suitable to all of them—the tax should be paid by the doctor who wrote the prescription. This sent your committee scurrying

about once again, when this disturbing fact was discovered, for there remained only one chance to straighten this out—that was in the conference committee, if the House could be induced not to concur in the Senate amendments and a conference committee could be appointed which would agree to the change. This was quite some job but it was done and the tax was taken off the doctor, Dr. George Denny, of Madison, Representative from Jefferson and Scott counties, doing noble service in this respect for the profession.

Now as The Journal goes to press a difference of opinion exists as to the interpretation of the bill by the attorney general's office. According to an unofficial opinion of that office, a doctor has the right to prescribe medicinal whisky but he has no legal right to possess it or to purchase whisky. That seems rather contradictory and is contrary to the federal statute that allows the physician to keep on hand for emergency use in his practice a certain amount of medicinal whisky but of course not for sale. There is nothing in this act or in the federal act intended to allow a doctor to sell whisky himself which is in accord with the best beliefs of the committee that *under no circumstance should any member of the profession be placed in a position where his prescribing of whisky possibly can be construed to be commercial.*

Right now there seems to be some disagreement between the authors of the bill and the attorney general's office as to whether or not a physician may purchase and possess whisky. Under the federal law he is allowed six quarts a year for his practice. It is a question as to whether this is legal or not under the Indiana statute.

Taxes

In so far as the final outcome was concerned it was known from the start that some sort of a sales tax or income tax would be necessary if property was to be relieved of this burden. With this in mind a representative of your committee attempted to have physicians exempted on the grounds that so much of their work was of a charity nature. When nothing could be done in that direction, largely through the efforts of your committee, the Ways and Means Committee of the House, to which all tax legislation is referred on introduction, went on record that any income tax that might be undertaken would include public officials, teachers, everyone who was not specifically exempt by the constitution of the United States. Thus if physicians are not exempt, neither is anyone else.

The original bill as introduced called for a two per cent gross sales tax which included physicians. Along with many other groups your committee strenuously opposed this tax. As a result the one per cent gross income tax bill was introduced and passed, along with the $1.00-$1.50 property rate limitation law which was designed to reflect an average 35 per cent cut in 1933 property taxes throughout the state collectible in 1934. This rate limit should be reflected among other things in office rent reductions when that rate reduction becomes effective.

In the legal column in this number of The Journal, Mr. Stump, attorney for the Association, gives a detailed discussion of the gross income tax and the intangible tax as they affect the members of the profession. Your committee fought on the losing side in the battles against any increase in the driver's license fee and for a deduction in the gasoline tax.

In Conclusion

Finally your committee wishes to thank each member of the various county legislative committees, and the many friends of the medical profession, who functioned so effectively and asks that the members of the Public Health Committees in both the House and the Senate, to which was referred most of the legislation affecting the medical profession, be remembered and formally thanked by the medical societies of the counties in which they reside. They all proved themselves to be friends of the medical profession.

Members of the House committee were: Bern B. Grubb, West Lafayette (Tippecanoe and Warren); William F. Schenk, M. D., New Corydon (Jay); Charles J. Allardt, South Bend (St. Joseph); E. Millard Dill, Plainfield (Hendricks); John W. Mertz, Corunna (DeKalb); Ray Gilbert, Seymour (Brown and Jackson); Thomas A. Hendricks, Indianapolis (Marion); Paul B. Sturm, Dana (Vermillion); Henry C. Asche, Sunman (Dearborn and Ohio); Herbert H. Evans, Newcastle (Henry); John W. Weaver, Elnora (Daviess); A. F. Nelson, Thorntown (Boone), and E. A. Tucker, Columbus (Bartholomew).

The Senate committee was composed of: George D. Miller, M. D., Logansport (Cass and Fulton); Jesse M. Ballard, Marion (Grant); John C. Gorman, Princeton (Gibson and Pike); Thurman A. Gottschalk, Berne (Adams, Blackford and Wells); Isaac N. Trent, M. D., Muncie (Delaware); Curtis E. White, Indianapolis (Marion); and Floyd I. Garrott, Battle Ground (Benton and Tippecanoe).

Signed:

George Daniels, Chairman,
J. W. Wright,
L. J. Danieleski,
F. H. Jett,
L. E. Fritsch,

Committee on Legislation and Public Policy.

The list of bills specially affecting the medical profession either as citizens or as doctors, and a brief statement of their most important features and their final disposition follows:

BILLS SIGNED BY GOVERNOR

TAXES

H. B. 44. Dyer, Mertz, Thompson. New delinquent tax law providing a method of paying delinquent taxes by taxpayer who has failed to pay his taxes for the year 1931 and any year prior to that. Not to apply in cases where property on which the taxes have been assessed and levied has been sold for such taxes. Installments are to bear 4 per cent. interest per annum, computed from the date delinquent until the date of the November, 1933, payment. Taxes and interest to be added. Waiving all existing legal penalties. Privileges granted not to waive, release or destroy validity or

priority of any lien of such taxes against the property or person. If any such chooses, he may pay the first installment for 1932 on or before the first Monday in May, 1933, and any taxes assessed against the property for 1932, on which he desires to pay such taxes, shall not be deemed due and payable until the regular taxpaying dates of 1933 and he is to have the right of paying such 1932 taxes in the same manner and at the same time as though all delinquent taxes had been paid. Any taxpayer availing himself of provisions may pay the whole of such delinquent taxes or may pay such in twenty equal installments with the accrued interest, the last payment being due in 1943. Failure to pay any installment when due in the twenty-pay plan with interest, shall cause the taxpayer to lose all rights and all delinquent taxes shall become due and payable at once with penalties and the property may be sold for taxes. All interest is to belong to the public treasury. Repealing tax delinquency law approved August 13, 1932. Emergency. Signed February 21.

H. B. 45. Ellyson-Wingate. Providing that none of the lands and lots returned and remaining delinquent for the non-payment of taxes, as shown by the lists prepared and recorded by the county auditor or other officer charged with that duty during the month of December, 1932, as provided by law, shall be offered for sale or sold or advertised for sale in 1933, but the first sale shall commence on the second Monday in February, 1934. Suspending all laws in conflict. The act is to expire by its own limitation July 1, 1933. Emergency. Signed January 19.

S. B. 320. Swihart. Authorizes county treasurers or other officers authorized to collect taxes during 1933 to accept checks drawn against account in any bank or trust company which is operating on restricted withdrawal basis in payment of taxes; check to be accompanied by statement signed by officer of bank that taxpayer's balance is sufficient to meet check; no receipt to be given, but treasurer to hold check until taxpayer's deposit is released by bank; taxes to be deemed paid and no interest or penalty shall be exacted. Emergency.

H. J. R. 1. Stein. Provides for submission of an amendment to the Indiana Constitution to give the general assembly authority to enact any kind of tax law. Broadens entire base of taxation. Signed March 1.

S. B. 319. Wickard, Ketchum and others. Repealing the 1932 $1.50 tax limit law, and rewriting it entirely to include amendments cutting the levy to $1 outside of incorporated cities and towns, but leaving it at $1.50 in the cities and towns; changes makeup of county board of tax adjustment to include one member of the county council and six other members to be appointed by the judge of the circuit court, one of whom must be a township trustee, one a mayor, one a member of the school board and the others to be representatives at large. Also authorizes boards to approve levies over and above the $1.50 law in order to meet obligations incurred before the law went into effect in 1932. A measure intended to protect the constitutionality of the $1.50 law.

H. B. 513. Stein, Finney, Walsman. Administration gross sales and income tax on persons and corporations. Effective May 1. Payments quarterly. Exemption of $1,000 on business and personal incomes. Act imposes following taxes: 1 per cent. on individual gross incomes; 1 per cent. on rental gross recepts; one-fourth of 1 per cent. on wholesale gross receipts; one-fourth of 1 per cent. on manufacturers' gross receipts. Act to be administered by department of treasury, which includes Governor, treasurer of state and one other person to be named by the Governor. County treasurers to be deputy collectors. Various penalties provided, including right to seize and sell personal and real property and even negotiable instruments to satisfy taxes. County prosecutors to enforce law for violations without extra pay and department may employ additional counsel to aid the prosecutor. Emergency. Signed February 27.

H. B. 476. Gardner, Jessup. Imposes an excise stamp tax of 25 cents on each $100 of intangibles other than bank and building and loan stock and deposits. Stamps to be issued by state board of tax commissioners and sold to intangible owners by county treasurers. Intangibles cannot be sold, transferred or mailed without stamps. Exempts intangibles from all other tax. Ways and Means.

H. B. 485. Jessup, Gardner. Imposes a tax of 25 cents per annum on building and loan stock to be collected from the building and loan associations by state board of tax commissioners. Exempts stock from all other taxes and eliminates the provision that permits owners of such stock to deduct their debts from the total of such stock owned, paying the tax on the balance. Ways and Means.

H. B. 486. Jessup, Gardner. Imposes a tax of 25 cents per annum on each $100 of bank deposits and stock, to be collected from banks, based on average monthly balance. Exempts bank stock from all other taxes. Ways and Means.

H. B. 516. Walsman. Amending the 1929 drivers' and chauffeurs' license law fixing the chauffeurs' drivers' license charge at 50 cents and requiring both to be renewed annually. Change in the drivers' license to take effect April 1, 1933, and the change in the chauffeurs' license to be effective as of January 1, 1933.

LIQUOR

H. B. 143. Ryan et al. Repealing the 1925 Wright bone dry law (Chapter 48, Acts of 1925), and all acts amendatory thereof or supplemental thereto. Emergency. Signed March 1.

H. B. 144. Ryan et al. Act regulating the manufacture, sale and distribution of alcoholic, malt and vinous beverages, malt syrup, malt extract, liquid malt and wort.

H. B. 526. Ryan, Downey. Setting up machinery for state convention for vote on repeal of the Eighteenth amendment. Providing that the Governor issue a proclamation fixing the date of election of delegates and that the proclamation not be issued more than forty-five days prior to election. Election may be at special or general election, but not more than and within three months from time the Governor received the congressional resolution. Providing for nomination by petition. Candidates for election as delegate must designate whether they are for or against ratification of the resolution. Each county to have one delegate and one for each 10,000 population or major fraction thereof. Emergency.

MEDICINE AND HEALTH

H. B. 277. Ryan. Authorizing the judge of any circuit, criminal or juvenile court to commit to any public hospital in the county or to any such hospital in an adjacent county any child under sixteen years old living in the county who is suffering from a disease, defect or deformity that may be treated at such hospital, and whose parent or legal guardian is not financially able to defray the necessary expenses of such treatment. Payment to the hospital for such treatment is to be made on order of the judge by the county where the afflicted child has legal residence. Emergency. Signed February 27. (This means that judges have the option in the future of sending cases of this character either to the Riley Hospital in Indianapolis or send them to their own county hospitals or that of an adjoining county. Up until this law was passed such cases had to be sent to the Riley Hospital.)

H. B. 101. Wickersham, Cantley. Amending 1852 law to provide that bonds of county coroners shall range from $1,000 to $5,000, leaving the exact amount to the discretion of the county commissioners and provides that coroners shall have the duty, in addition to all others, of arresting persons guilty of rioting. Present law fixes coroner's bond at a flat rate of $5,000.

H. B. 100. Wickersham, Cantley. Accords to all hospitals a right to claim a lien against all judgments based on injuries on account of negligence of a third party where a hospital had rendered services to the injured party and the expense of such services was an element in the damages allowed. As originally introduced this bill gave much fuller powers to the hospitals in this regard. This met the opposition of the insurance companies and the bill was only passed after a compromise had been reached which limited the provisions of this act strictly to a lien against judgments. Your legislative committee took no part in this controversy as the state association had already reached an agreement with the insurance carriers that physicians should have patients carrying insurance sign blanks assuring physicians of consideration in the collection of his fees in injury cases. Under this

agreement the physicians have greater leeway than have the hospitals under this law.

H. B. 227. Braun, Randall. Act providing for operation of county tuberculosis hospital in Allen county. Provides that board of commissioners of any other county contracting for treatment of any of its citizens in this hospital shall appoint an official visitor and inspector of such hospital.

H. B. 167. Regester. Amending existing law that provides for a personal representative of a person killed by wrongful act or commission to bring suit within two years for damages not exceeding $10,000 for the act or omission. Amendment provides that if the decedent leaves no dependent the personal representative may maintain such action and damages shall inure to exclusive benefit of person that provided hospitalization or hospital services to the decedent in connection with his last illness or injury, not to exceed $200; to those who gave medical or surgical services not exceeding $100; to the undertaker for funeral and burial expenses not to exceed $300; reasonable attorney's fees, not exceeding $250. Signed March 2.

S. B. 172. Biddle. Requiring the nature of alcoholic drinks and narcotics and their effects on the human system must be included in the subjects taught.

S. B. 139. Egan. Proposes to repeal the laws relating to the possession and distribution of narcotic drugs and to enact the uniform narcotic drug act. As originally drawn and as it passed the Senate this bill would have meant that the physicians of the state would have been forced to keep and maintain additional records of narcotics administered. These obnoxious provisions were stricken out by the House Committee on State Medicine and Public Health. As the bill was signed by the Governor it gives narcotic agents the right to apprehend narcotic addicts who possess drugs. Under the Indiana law this has not been entirely possible in the past.

H. B. 68. Gwin, Mohlman, Denny. Creating a board of barber examiners, regulating the practice of barbering, providing for registration and regulation of barber schools.

BECAME LAW WITHOUT GOVERNOR'S SIGNATURE

S. B. 201. Hardy. Providing that persons, and their heirs, legatees, devisees and personal representatives of persons who became freehold sureties and became obligated, without compensation, on any personal bonds to secure deposits in a bank, banking institution or trust company designated on or after January 1, 1927, as a public depository of public funds of any governmental or school unit, other than the state, are relieved from all liability to the extent that deposits secured by such bond or bonds represent funds raised by general taxation in the municipal corporation or political subdivision making such deposits. Emergency. Became a law without signature of Governor March 1. (As many physicians communicated with the members of the committee asking support of this measure it is carried here although it affects intimately only a small number of doctors.)

BILLS FAILING TO PASS

H. B. 148. Radabaugh, Hoffman, Eshelman, Braun, Galloway, Regester and Asche. Chiropractic bill creating state chiropractic board of three appointed by Governor. Provided for registration for those who pass examination following payment of an examination fee of $25 and registration fee of $5. Reported out of committee with a unanimous recommendation for indefinite postponement which was adopted on floor of the House.

S. B. 270. Webb, Evans, Tormohlen. Senate chiropractic bill creating an independent chiropractic board. Chiropractic is defined as the science of locating and correcting any interference with nerve transmission and expression. Died in Senate after getting through second reading.

H. B. 402. Galloway. Repealed sections of 1927 law which allows injunctions against persons who practice medicine when not licensed to do so. This was the second attempt in the House by the cultists to wreck the medical law. This time they sought to strike out the injunction clause—the heart of the medical practice act.

H. B. 53. Eshelman. Beauty parlor bill licensing cosmetologists or beauty doctors and setting up qualifications for beauty doctors and defining cosmetologists.

H. B. 176. Spurgeon, Dill, Gilbert. Would have removed provision that parents or guardians of pupils can halt medical examinations through written objections—thus giving school officials full authority to make examinations. Vigorously opposed by Christian Scientists and League for Medical Freedom. Killed as it was said to violate the constitutional right of the individual to religious liberty.

H. B. 177. Spurgeon, Denny, Dill, Gilbert. Would have removed provisions for exempting physically disabled school children from physical examinations before entering special classes. Would have amended 1927 act for special education of physically deficient children. Opposed by same groups as were against H. B. 176.

H. B. 414. Spurgeon, Schenk. Proposed to authorize public school authorities to order the examination of school children by licensed physicians and if the examinations disclose the presence of contagious, infectious or communicable diseases to exclude afflicted children from school during the course of such diseases. Opposed by Christian Scientists on the grounds of religious freedom. Postponed in House.

H. B. 185. Richardson. Would have required hospitals to keep records of the treatment and medical history of their patients under their care. Such records were to be admissible as evidence in the courts but only so far as they relate to the treatment and medical history. Indefinitely postponed in House.

H. B. 435. Tighe. Proposed to repeal the law authorizing the sexual sterilization of certain socially inadequate inmates of state institutions. Indefinitely postponed in House.

H. B. 318. Ryan. Provided the appointment of five resident optometrists to comprise state board of registration and examination of optometry instead of the present setup in which four are optometrists. This bill would have cut out all advertisements reading: "Eyes Examined Free." Passed House but died in the Senate.

H. B. 354. Grubb. Poison bill proposing to make it unlawful to distribute in any manner enumerated poisons, hypnotic drugs or chemicals without labeling the containers with the name of the article and the word "poison" printed in red letters. Records of these articles were to be kept by the seller for five years. This act was not to apply, however, to drugs dispensed on the prescription of licensed physicians, dentists, or veterinarians. Persons other than registered pharmacists, physicians, veterinarians, and dentists were to be prohibited from selling or dispensing acetanilidum, acetphenetidinum, acidum barbituricum, amidopyrina, or antipyrine. Passed House but killed in Senate.

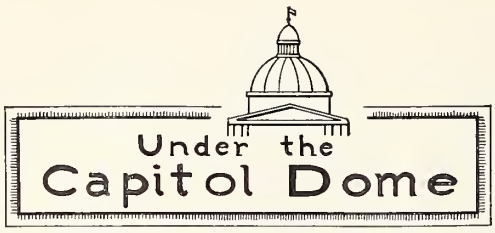
H. B. 320. Robbins, Walsman. Compensation bill, liberalizing the Indiana workmen's compensation law. Provided among other things that employer should supply free of charge to an injured laborer or employee an attending physician, surgical and hospital service for the first thirty days following an injury. Employee was to receive in addition to other compensation 55 per cent. of his average weekly wage for certain periods, based on the extent of the injury. The weekly wage was not to be considered more than $30 weekly nor less than $16. Failed to pass in House.

S. B. 277. Watson. Proposed to accord hospitals treating persons injured through the fault of other persons liens on all rights of action, claims, judgments, settlements or compromises accruing to the injured persons because of their injuries. This lien, however, was not to attach to claims under the workmen's compensation act. Died in the Senate after being reported out of committee favorably for passage.

S. B. 167. Weiss. Amended the narcotic drug act, proposing to permit licensed podiatrists to dispense and prescribe narcotic drugs. Failed to get out of Senate.

H. B. 171. Evans, Grubb. Authorizing county commissioners in any county, if they deem it advisable, to establish county commissary for poor relief, authorizing county commissioner to rent quarters, contract for food, fuel, clothing and medical attention and rents and do all things necessary to operate commissary. Commissary deficits to be made up from county general fund.

S. B. 305. Smith. Giving county commissioners the authority to abolish the office of county health commissioner. Passed Senate but was indefinitely postponed by the House Committee on Public Health and State Medicine.



New Indiana road maps have just been received by the state highway commission from state printers. Copies may be obtained without cost by dropping a letter to the highway commission and requesting the maps.

* * *

Paul Fry, who has been named state excise director in charge of both medicinal liquor and beer permits, announces that he is considering the preparation of regular form prescriptions for use of physicians who wish to prescribe whisky. However, until the forms are prepared, and perhaps as a permanent policy, physicians are instructed to use their regular prescription blanks in cases where alcoholic liquors are prescribed for patients. The excise director has been only recently appointed and naturally has not yet set his machinery into motion.

* * *

By June 30 all state employes, including trustees of the state's institutions, will be directly responsible to the Governor under provision of the departmental consolidation act passed by the 1933 General Assembly. The Governor then will have full authority to remove any employe or trustee. In the meantime he will have the same authority in departments which he takes over under the consolidation plan.

Several Indiana physicians are members of the boards of trustees of state institutions. Under the old order these trustees were appointed for definite terms, generally for four-year periods, and were subject to removal only in cases of grave offenses.

This same rule applies to members of various commissions and boards, including the board of health and medical board.

* * *

Co-operation of Indiana druggists to prevent drugless physicians from prescribing medicines is being asked by Dr. William R. Davidson, secretary of the board of medical registration. In a letter to Frank McCullough of New Albany, secretary of the Indiana Pharmaceutical Association, Dr. Davidson said: "I can cite you to several instances where chiropractors, naturopaths and other drugless physicians have prescribed medicine to their patients, giving the prescription to the pharmacist over the telephone or verbally, without signing. This method is followed in order to circumvent the law. Without signatures to prescriptions it is impossible to successfully prosecute a violation of the law.

"If the pharmacists will aid us by requiring such drugless physicians to sign their prescriptions, we will be in a position to see that the law is not violated by persons who are by statute expressly forbidden to prescribe or dispense drugs," the letter said.

* * *

Hospitals, according to Attorney General Lutz, will have no greater power under the new liquor control act than they had before its passage. "Hospitals will, of course, be permitted to continue in the use of alcohol and preparations containing alcohol for medicinal purposes so long as the same is not used for beverage purposes," the Attorney General ruled. "Hospitals are not permitted to use or prescribe spiritous beverages or alcoholic beverages, reasonably likely or intended to be used as a beverage. In the event the use of such spiritous beverages is necessary in the treatment of any patient in such hospital, the necessary prescription will have to be issued by a person authorized under the provisions of the National prohibition act to issue such prescription, and such prescription will have to be filled by a druggist holding a permit under the laws of Indiana."

It has been learned, from proper authority, that the state excise director will, within a few days, issue a regulation which will allow a physician to possess medicinal whisky in Indiana under the same regulations as allowed by Federal law. This would mean that Indiana physicians legally may keep twelve pints of whisky for emergency medicinal purposes.

Two important unofficial opinions concerning the dispensing and possession of medicinal whisky and alcohol have been issued during the month by Philip Lutz, Jr., attorney general of Indiana.

One of his principal findings is that "the provisions of the Federal law which permit the possession of certain quantities of intoxicating liquors to be kept in stock by physicians, hospitals and dentists for internal administration to patients do not apply to Indiana."

This interpretation of the effect of the state's new liquor control law was stated in a letter to the Washington, D. C., law firm of Cooke & Beneman.

On this same subject, the attorney general in an unofficial opinion of W. H. Kennedy, acting supervisor of permits, bureau of industrial alcohol, had this to say: "The law does not authorize the possession of intoxicating liquors by doctors or dentists for administering to patients, hence there is no permit for such purposes. The only method by which patients can secure spiritous alcoholic beverages, such as whiskey, brandy, rum and gin, is upon prescription issued in conformity with the provisions of the national Prohibition Act, and the presentation of such prescription to a druggist in the State of Indiana holding a permit from the state as required by section 24 of the Indiana act."

The attorney general held also that the new Indiana act does not require the issuance of an Indiana permit to prescribe spiritous beverages, but limits that right to persons authorized to do so by the Federal law.

SECRETARIES' COLUMN

Dr. Linder, past president of the King's County Medical Society, Brooklyn, N. Y., says that "clinics are taking away from the general practitioner the things that rightfully belong to him.... The general practitioner is the backbone of the profession.... He should be helped and not stepped upon." These thoughts are directly opposite to those voiced by the Committee on the Costs of Medical Care.

I see Mr. Cook is carrying on the propaganda of the now extinct Committee on the Costs of Medical Care. Perhaps Mr. Filene will be satisfied some day that the medical profession is made up of real men. How would Mr. Filene like the group plan applied to his department store in Boston?

Did you read "Doctor, We Are At Your Service," in the March issue of the *American Legion Monthly?*

The Committee on Secretaries Conference would like suggestions from the secretaries on the kind of program they would like to have at their next annual conference. Please send in your ideas.

Have you had a meeting in your Society devoted to medical economics? If not, why not? Lots of good can be derived from a meeting of this kind.

Preventive medicine and periodic health examinations are popular today. Do you read the *Health Examiner* published by the Greater New York Committee on Health Examination, 2 East 103rd St., N. Y.? This is the address of the New York Academy of Medicine.

It is ——— if you do and ——— if you don't. The following was taken from the January number of the Journal Michigan State Medical Society:

"If a secretary writes a letter, it's too long.
If he sends a postal, it's too short.
If he doesn't send a notice, he's lazy.
If he attends a committee meeting, he's butting in.
If he stays away, he's a shirker.
If he duns members for dues, he's insulting.
If he fails to collect dues, he's slipping.
If he asks for advice, he's incompetent,
If he does not, he's bullheaded.
If he writes complete reports, they are too long,
If he condenses them, they are incomplete.
If he talks on a subject, he's trying to run things,
If he remains quiet, he has lost all interest in meetings.
Ashes to ashes,
Dust to dust;
If others won't do it,
The Secretary must.

The above represents the true life of a county medical society secretary.

A. M. Mitchell, M. D.

"VOICE OF THE DOCTOR"

Illumination for Darkfield Examination

Here is a suggestion which may be of benefit to those in the field of laboratory technic or in the field of syphilology.

After experimenting for a number of years with different types of illuminating devices for a Darkfield examination, I have found that a photoflood light manufactured by the General Electric Company, and retailing at thirty-five cents through any camera supply house, makes the most efficient and cheapest form of light. This bulb is the approximate size of an ordinary 60 watt bulb, but delivers about 750 candle power. It may be used on any 110 volt light current. The bulb itself can be easily slipped under the stage of any ordinary miscroscope. It gives a very brilliant, white light much more so than the smaller types of lights that use a transformer. It does not have any of the awkward features that go along with an arc light. No special fittings are necessary other than a drop cord with an ordinary socket. A tin hood can be easily constructed which will take care of any glare that might be present.

John R. Brayton, M. D.,
Indianapolis.

Diphtheria Immunization in West Lafayette

Last fall the Public Schools of West Lafayette were threatened with an epidemic of diphtheria through the appearance of the disease in the neighboring City of Lafayette. There a number of cases developed in November with several fatal terminations.

The Parent-Teachers Association, being largely wives of Purdue faculty members and others having the cultural background of University training and influence, afforded an unusual opportunity for intelligent co-operation.

The physicians resident in West Lafayette volunteered their services for the emergency. The School Board furnished the supplies. Analysis of the statistics is interesting.

At 5 and 6 years of age, those showing positive after previous immunization numbered 1 in 13. In the age bracket of 6 to 10 years, it was 1 to 8. From 10 to 15 years, it was 1 to 4.

At the age of 5 and 6 years, 18 had no previous immunization and 17 of these showed susceptibility. From 6 to 10 years, 213 of the 301 had not been immunized and of these only 133 reacted, or 62%. From 10 to 15 years, 86 had been immunized. Of

the 166 who had not received the prophylaxis, 111 failed to show immunity, or 67%.

Of the 33 teachers submitting to the test, 17 proved reactors, 50%—and one developed the contagion.

The 1 reactor in the 5 to 6 year class had been immunized in 1929—3 years.

In the 6 to 10 year class, the reactors had received immunization—1-10 yrs; 1-6 yrs; 1-5 yrs; 1-4 yrs; 3-3 yrs; 2-2 yrs; 2-1 yr.

In the 10 to 15 year class, those reacting had their immunization—5-6 yrs; 1-5 yrs; 7-4 yrs; 2-3 yrs; 2-2 yrs; 2-1 yr.

In the High School, 8 reacted, whose immunization had been—2-10 yrs; 1-8 yrs; 1-4 yrs; 1-3 yrs; 1-2 yrs; 1-1 yr; 1 failed to obtain immunity.

The interest aroused by the test was highly educational. Those reacting were given a letter to their parents advising consultation with their family physician. An effort was made to explain the limitations of the test and its possible implications, but placing the responsibility on the family physician for any action deemed advisable. From follow-up information received, this resulted in 71 receiving toxin antitoxin, or toxoid; 17 received prophylactic doses of antitoxin; and in 10 other instances the family physician advised against any action.

REPORT OF SCHICK TEST

Morton School

Total Enrollment 688
Number taking test at school.....584
Number taking test by family physician..... 39
Total taking test 623
Percentage taking test..... 90.5%
Number of positive reactions.....291
Number of positive who had been immunized..... 32
Number of negative reactions.....293
Number of negative who had been immunized.....187

Distribution by age.

Ages 5 to 6 years—
Total taking test..... 31
Number of positive reactions..... 17
Number of positive who had been immunized..... 1
Date of immunization 1929
Number of negative reactions..... 14
Number of negative who had been immunized..... 12
Ages 6 to 10 years—
Total taking test.....301
Number of positive reactions.....144
Number of positive who had been immunized..... 11
Dates of immunization—1922-1926-1927-1928-1929-1929-1929-1930-1930-1931-1931.
Number of negative reactions.....157
Number of negative who had been immunized..... 77
Ages 10 to 15 years—
Total taking test.....252
Number of positive reactions.....130
Number of positive who had been immunized..... 19
Dates of immunization—1926-1926-1926-1926-1927-1928-1928-1928-1928-1928-1929-1929-1930-1930-1931-1931-1926-1928.
Number of negative reactions.....122
Number of negative who had been immunized..... 67
Teachers—
Number taking test..... 20
Number of positive reactions..... 9

High School

Total enrollment 277
Total taking test.....228
Percentage taking test..... 82.3%
Number of positive reactions..... 74
Number of positive who have been immunized..... 8
Dates of immunization—1922-1922-1924-1928-1929-1930-1931-one unable to immunize.
Number of negative reactions.....154
Number of negative who had been immunized..... 69
Teachers—
Number taking test..... 13
Number of positive reactions..... 8

Summary for System

Total enrollment in system.....965
Total taking test in school.....812
Percentage taking test in school..... 88.2%
Percentage of positive reactions..... 45%
Total who had been immunized.....264

Morton School

Toxoid and Toxin-antitoxin given..... 71
Antitoxin given 17
Doctors advised no prophylaxis..... 10
Moved 2
Teachers—
Toxoid and Toxin-antitoxin..... 8

High School

Toxoid and Toxin-antitoxin..... 5
Antitoxin 3
Teachers—
Toxoid and Toxin-antitoxin..... 4

F. S. Crockett, M. D., Lafayette, Ind.

Diphtheria Report for February, 1933

There were ten diphtheria deaths for February as compared with 17 for last year. We now have for the first two months of the year 28 deaths as compared with 42 at the same time last year, or exactly two-thirds. This report is most gratifying and is somewhat confirmed by the fact that a smaller number of cases are being reported than for the corresponding months last year. We very much hope that diphtheria has started down. In case it is, now is the time to strike. The people and the doctors of the state have become diphtheria conscious. There is not a bit of reason to doubt that there will be an increase again next fall provided we do not forestall it with extensive anti-diphtheria work in the intervening time. The summer time, as everyone knows, is sluggish and so we should take advantage of the remaining months of school.

Interesting indeed and somewhat alarming is the fact that the deaths are showing a different distribution from that of last year. Nearly all of the deaths so far have been in the southern part of the state. Marion County in two months has had five deaths, whereas last year for the whole year it had six, and for 1931 it had eight. This probably means that those counties which have had comparatively little diphtheria have become careless and are now in for a definite epidemic unless they pick themselves out of that attitude.

The following summary will give the figures for February and the year of 1933.

County	Total for 1933	February, 1933
Allen	1	0
Daviess	2	0
Dubois	1	0
Harrison	1	1
Howard	1	0
Lake	1	0
Marion	5	3
Monroe	1	0
Parke	1	1
Pike	1	1
Ripley	1	0
Shelby	2	0
Sullivan	2	0
Switzerland	1	1
Tippecanoe	3	2
Vigo	1	0
Wayne	1	0
Wells	1	0
Vanderburgh	1	1
	28	10

DEATH NOTES

James Oliver White, M. D., of Worthington, died February seventeenth, aged eighty-one years. He graduated from the Kentucky School of Medicine, Louisville, in 1893, and from the Keokuk Medical College, Keokuk, Iowa, in 1894. Dr. White was not in active practice.

Benjamin R. Smith, M. D., of Pershing, died February twelfth, aged eighty-eight years. Dr. Smith was one of the few surviving veterans of the Civil War, during which he served in the Union Army. He graduated from the Starling Medical College, Columbus, in 1870.

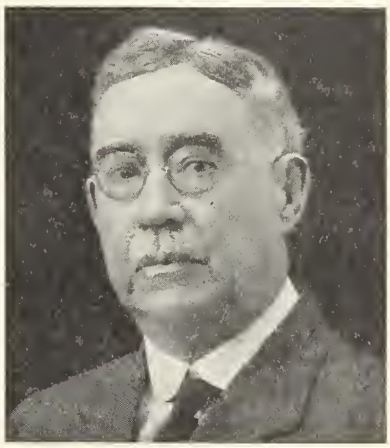
Oscar R. Meyer, M. D., of Lanesville, died March seventh, aged fifty-one years. Dr. Meyer was a member of the Harrison County Medical Society, the Indiana State Medical Association and the American Medical Association. He graduated from the Kentucky School of Medicine, Louisville, in 1907.

Lindley Hastings Stafford, M. D., of Indianapolis, died March twelfth, aged forty-eight years. During the World War, Dr. Stafford served as a captain in the medical corps. He was a member of the Indianapolis Medical Society, the Indiana State Medical Association and the American Medical Association. He graduated from the Physio-Medical College of Indiana, Indianapolis, in 1907.

Accie E. Mathews, M. D., of Franklin, died February thirteenth, aged seventy-one years. Dr. Mathews had practiced medicine in Franklin for more than thirty-eight years. She was a member of the Johnson County Medical Society, the Indiana State Medical Association and the American Medical Association. She graduated from the Northwestern University Woman's Medical School, Chicago, in 1893.

William T. Gott, M. D., one of Crawfordsville's best known residents, and one of Indiana's prominent physicians, died February twenty-fourth, after an illness of several weeks. He was seventy-seven years of age.

Dr. Gott had been a member of the State Board of Medical Registration and Examination since



William T. Gott, M. D.

1897, serving the Board for some years as president and for many years as secretary. He was the first health officer elected in Montgomery County; he served as president of the United States Board of Pension Examining Surgeons in his locality; he conducted examinations of applicants for service in the Spanish-American war; and he was a member of the executive committee of the Indiana Council of National Defense during the World War.

Dr. Gott was a member of the Montgomery County Medical Society, the Indiana State Medical Association and the American Medical Association.

An editorial concerning Dr. Gott appears in this issue of The Journal on page 177.

Samuel Horton Havice, M. D., of Fort Wayne, died March first, aged seventy-two years. Dr. Havice was an ophthalmologist and otolaryngologist and had practiced in Fort Wayne for forty-two years. He was a member of the Allen County Medical Society, the Indiana State Medical Association and the American Medical Association. He graduated from the Bellevue Hospital Medical College, New York, in 1884.

HOOSIER NOTES

Dr. S. R. Edwards, of South Bend, has gone to Europe where he will do some postgraduate work.

The Ripley County Medical Society met at Osgood, March seventh.

Dr. Richard Stephenson, of West Lebanon, has been appointed health commissioner for Warren County.

The Boone County Medical Society held its regular monthly meeting, preceded by a dinner, at the Rader Home Cafe, Lebanon, March seventh.

Dr. Virgil Scheurich, who has been assisting Dr. J. C. Freed, in Attica, has located in Oxford for the general practice of medicine.

Dr. and Mrs. M. Joseph Coomes have moved from Napoleon to Versailles, where Dr. Coomes will conduct a general practice.

Dr. T. N. Siersdorfer, of Indianapolis, has taken over the office and equipment of the late Dr. C. D. Lane, of Ligonier, and is practicing there.

Dr. A. E. Newland, of Bedford, has announced the removal of his office from the Citizens Bank Building to 1114 Fifteenth Street.

Dr. L. N. Ashworth and family have moved from Connersville to Greensburg where Dr. Ashworth will conduct a general medical practice.

Dr. Joseph H. Weinstein, of Terre Haute, was the principal speaker before the Woman's Auxiliary of the Indianapolis Medical Society, March third.

Dr. Henry F. Vaughn, of Detroit, talked to members of the Indianapolis Medical Society at the Athenaeum, March fourteenth. His subject was "Medical Participation in Public Health Work."

Members of the Lake County Medical Society met at St. Margaret's Hospital, March ninth. The program was presented by members of the staff of the hospital.

Miss Iona Mae Brandenburg, of Connersville, and Dr. R. G. T. Watterson, of Glenwood, were married February fifteenth. Dr. Watterson is associated with Dr. Virgil Fruth, in Connersville.

Dr. John R. Caulk, of St. Louis, was the principal speaker before the members of the Fort Wayne Medical Society March twenty-first. He discussed the transurethral method of prostate removal.

The Jay County Medical Society will meet at Portland, April seventh, to hear Dr. George V. Cring discusss "The Annual Examination of School Children."

Members of the Delaware-Blackford County Medical Society met at the Hotel Roberts, February 21st. The sociological aspects of medical practice were discussed.

Dr. R. A. Solomon, of Indianapolis, presented a paper on "Non-tuberculous Diseases of the Lung" before the Jay County Medical Society, March third, at the Portland Country Club.

The Henry County Medical Society met at the Henry County Hospital, Newcastle, March ninth. Dr. Harold Swanberg, of Quincy, Illinois, read a paper entitled, "Radium Therapy in Uterine Hemorrhage." Attendance numbered twenty.

At the March second meeting of the Elkhart County Medical Society, in Elkhart, Dr. J. Dewey Bisgard, of Ann Arbor, Michigan, presented a paper on "Arthritis of the Spine."

Members of the Madison County Medical Society met at the Anderson Hotel, Anderson, February twentieth, for a dinner meeting. Dr. L. G. Zerfas, of Indianapolis, discussed "Pneumonia."

The Decatur County Medical Society met at Greensburg, February fifteenth. This was a general business meeting, with no scientific paper presented.

Dr. J. H. Warvel, of Indianapolis, talked to the members of the Tipton County Medical Society at the February twenty-third meeting. His subject was "The Diabetic Patient."

Members of the Daviess-Martin County Medical Society met February twenty-eighth at the Daviess County Hospital. Moving pictures concerning medical, surgical and obstetrical subjects were shown.

Members of the Green County Medical Society met at the Freeman County Hospital, Linton, February sixteenth. Dinner was served by the nurses of the hospital.

Dr. Max Thorek, of Chicago, was the principal speaker before the Muncie Academy of Medicine, February seventh. He discussed the surgical correction of physical defects.

Members of the Gibson County Medical Society met at the Kidd Hotel, February thirteenth. Dr. E. Vernon Hahn, of Indianapolis, presented a paper on "Better Technique in Office Surgery."

Dr. John R. Brayton, of Indianapolis, addressed the members of the Muncie Academy of Medicine, February fourteenth. His subject was "Some Pertinent Facts About Syphilis."

"The Adolescent Child" was the subject presented by Dr. J. F. Porter before the High School Parent-Teacher Association at Noblesville, February fourteenth.

Dr. John Warvel, of Indianapolis, talked about "Diseases Caused by Blood Infections" before the members of the Montgomery County Medical Society, at the Culver Hospital, February sixteenth.

The out-patient service of the Indianapolis City Hospital has been divided into eight districts and eight physicians have been appointed to have charge of these districts in order to perfect the service.

Dr. Robert M. Moore, of Indianapolis, addressed the members of the Fort Wayne Medical Society, February twenty-first. His subject was "The Heart as a Surgical Risk."

Dr. Frank Fee, of Cincinnati, talked before the members of the Wayne-Union County Medical Society at Richmond, February twenty-third. His subject was "Office Treatment of Common Rectal Diseases." Attendance numbered thirty.

Members of the LaPorte County Medical Society met in LaPorte, February sixteenth, to hear Dr. Milo Miller, of South Bend, discuss "Emergencies of Pediatrics." Eighteen members attended the meeting.

At the February fourteenth meeting of the Kosciusko County Medical Society, Dr. Russell E. Phillips reviewed the meeting of county secretaries in Indianapolis. The meeting was a dinner meeting held at the Hotel Hayes, Warsaw.

The Morgan County Medical Society met at Martinsville, March eighth and elected officers for the current year, as follows: president, Dr. M. C. Pitkin; vice-president, Dr. R. H. Richards; secretary, Dr. Leon Gray.

Fifty physicians from Noble, Lagrange, Dekalb and Steuben counties attended the meeting of the Northeastern Indiana Academy of Medicine at Kendallville. Dr. A. J. Sparks, of Fort Wayne, presented a paper on "Hematuria."

Members of the Madison County Medical Society met at the Anderson Hotel, March twentieth, for a dinner meeting. Dr. Paul A. O'Leary, from the Mayo Clinic, was the principal speaker, his subject being "Therapeutic Problems in Syphilis."

The Hamilton County Medical Society met at Carmel, March fifteenth. Dr. Robert M. Moore, of Indianapolis, presented a clinic and discussion of heart cases in general. Twenty members attended the meeting.

The Orange County Medical Society met at West Baden, March seventh, to hear Dr. John H. Warvel, of Indianapolis, discuss "Treatment of Anemia." Dr. Fred Cheney, of Indianapolis, presented case reports of primary pernicious anemia and hyperchronic anemia.

The March seventh meeting of the Fort Wayne Medical Society was held at the Chamber of Commerce Building. Dr. B. W. Rhamy presented a lecture, lantern slides and case reports on the leucocyte picture with a special discussion of the Schilling count.

The regular meeting of the Sullivan County Medical Society was held at the Mary Sherman Hospital, Sullivan, March first. Some case reports and a discussion of the endocrines were presented by Drs. J. A. and Margaret Ikemire, of Palestine, Illinois.

Members of the St. Joseph County Medical Society met at South Bend, February fifteenth. Dr. J. P. Greenhill, of Chicago, discussed the recent progress in obstetrics and gynecology and presented a four-reel moving picture of breech presentation. Attendance numbered sixty.

A dinner meeting of the Kosciusko County Medical Society was held at the Hotel Hayes, Warsaw, February fourteenth. A report of the state secretaries meeting was given. On February twenty-first a special meeting of the society was called to discuss Township Poor Relief.

MEMBERS of the LaPorte County Medical Society met at Michigan City, in the Spaulding Hotel, March sixteenth, to hear Dr. Herman Kretschmer, of Chicago, discuss the modern treatment of bladder neck obstructions. Attendance numbered thirty-eight.

WILLIAM F. MOLT, M. D., of Indianapolis, presented a paper on "Bronchoscopy" before ten members of the Hendricks County Medical Society, at Danville, February seventeenth. This was an illustrated lecture. Dr. Molt was assisted by Dr. John F. Rigg.

A MEETING of the Wabash County Medical Society was held at the Wabash County Hospital, February first. Dr. G. W. Gustafson, of Indianapolis, presented a paper on "Obstetrics." Drs. Shuler and Ferry, of Kokomo, discussed the care of the indigent in Howard County.

DR. C. J. ADAMS, of Kokomo, addressed the Rotary Club of that city, February fourteenth. Dr. Adams discussed the local poor relief situation and explained that the physicians of the community are giving their services at cost and less than cost in most instances.

THE Huntington County Medical Society met at the Hotel Lafontaine, Huntington, February seventh, for its regular monthly meeting. Dr. Beaumont S. Cornell, of Fort Wayne, was the principal speaker; his subject was "Heart Disease."

DR. A. G. TILLOTSON, of Michigan City, recently observed the sixty-fourth anniversary of his entrance into the practice of medicine in Michigan City. Dr. Tillotson is eighty-five years of age, and while not actively practicing any longer, he still prescribes for a few of his old friends occasionally.

DR. ROBERT M. MOORE and Mr. Bern B. Grubb were speakers before the Tippecanoe County Medical Society at Lincoln Lodge, and at the Home Hospital, Lafayette, March ninth. Dr. Moore discussed "Cardiac Patients as Surgical Risks" and Mr. Grubb presented "The Inside Facts of Our Legislature." Attendance numbered fifty.

MEMBERS of the Hancock County Medical Society met at Bowman Hotel, Greenfield, March tenth. Dr. H. H. Wheeler, of Indianapolis, presented a paper on "Hemorrhoids and Their Treatment." The time of meeting of this society has been changed to the second Monday night of each month.

AT THE March third meeting of the Howard County Medical Society, at the Courtland Hotel, Kokomo, Dr. A. M. Mendenhall, of Indianapolis, talked on "Management of Certain Types of Obstetrical Cases." Attendance numbered twenty. Nurses of the Good Samaritan Hospital were guests.

"USE of Surgical Maggots in Osteomyelitis" was the subject presented by Dr. E. L. Hedde before members of the Cass County Medical Society, at Logansport, February seventeenth. A motion picture film concerning surgical maggots was presented through the courtesy of the Petrolagar Laboratories.

MEMBERS of the Jasper-Newton County Medical Society met in Kentland, February twenty-seventh. Dr. Frank Hunter, of Lafayette, was the guest speaker, his subject being "Laboratory Technique for Physicians." Twenty-four members and guests were present. This was a dinner meeting, at the home of Dr. W. C. Mathews, in Kentland.

TWENTY-SEVEN doctors and nurses attended the February twenty-seventh meeting of the Jefferson County Medical Society at Madison. William F. Stock, of Mead Johnson and Company, presented several motion picture films concerning surgery, obstetrics and pediatric nursing. The meeting was preceded by a dinner at the Hillside Hotel.

DR. FRANK C. MANN, of Rochester, Minnesota, has been awarded the William Wood Gehard medal by the Pathological Society of Philadelphia, Pennsylvania, for his work on the physiology of the liver. Dr. Mann was born in Indiana, and is a graduate of the Indiana University School of Medicine.

MORE than seventy Gary physicians attended the Mercy Hospital staff meeting to hear Drs. S. J. Fogelson and A. J. Atkinson, of Northwestern University, discuss the use of mucin in the treatment of gastric ulcers. The meeting was held March seventh.

MEMBERS of the Gibson County Medical Society met at the Gibson County Methodist Hospital, Princeton, March thirteenth. Dr. McIntosh, of Mt. Carmel, Illinois, presented a paper on "Differential Diagnosis and Treatment of Ludwig's Angina." Two reels of motion pictures on "Breech Extraction" were shown. Twenty-eight attended this meeting.

At the February fourteenth meeting of the Vigo County Medical Society, with sixty-one in attendance, a committee of fifteen reported on a plan to care for the indigent sick. A motion picture on skin cancer was presented. This was the first meeting of the Vigo County Society having to do with economics; there will be several meetings in the future devoted to this subject.

A special meeting of the Elkhart County Medical Society, February seventeenth, was in honor of four veteran practitioners of the society—Drs. I. W. Short, C. W. Frank and F. N. Dewey, of Elkhart, and W. B. Kreider, of Goshen. A fifth member, Dr. C. L. Dreese, of Goshen, was unable to attend the meeting. The society plans to hold a similar meeting in tribute to four or five other old-time members within a short time.

Members of the Wells County Medical Society held their annual election of officers at a meeting in Bluffton, February twenty-first. Officers were elected as follows: President, Dr. H. D. Brickley, Bluffton; vice-president, Dr. C. N. Baganz, Uniondale; secretary-treasurer, Dr. Max M. Gitlin, Bluffton; delegate to state convention, Dr. D. C. Wybourn, Ossian; and alternate delegate, Dr. H. D. Caylor, Bluffton.

The sixth annual meeting of the Indiana Roentgen Society was held in Indianapolis, February twenty-second. Dr. E. R. Witwer, of Detroit, was the principal speaker. Officers were elected as follows: president-elect, Dr. W. R. Cleveland, Evansville; vice-president, Dr. H. H. Inlow, Shelbyville; secretary-treasurer, Dr. James N. Collins, Indianapolis; president for this year is Dr. R. L. Lochry, Indianapolis.

May, 1933, will be the one hundredth anniversary of the practice of medicine in Wabash County, Indiana. According to Dr. James T. Biggerstaff, of Wabash, who has spent much time collecting historical data for the period, the first case cared for by the medical profession in Wabash County was in May, 1833. During the century, 142 physicians have practiced in Wabash County. Dr. Biggerstaff has compiled an alphabetical list of the names of all physicians who have practiced in Wabash County during the one hundred year period.

American Delegates to the International Goiter Conference in Berne, Switzerland, August 10th to 12th, 1933, will sail from New York, July 26th, and reach France, August 6th. In the course of the passage a program of round table discussions on goiter will be conducted daily. Members of the medical profession in good standing in their state or provincial societies who may wish to join the delegation in an unofficial capacity may do so by communicating with Dr. J. R. Yung, Terre Haute, Indiana. Special rates have been provided.

For its sixtieth annual meeting, which will be held at LaPorte, Indiana, April eleventh, the Northern Tri-State Medical Association has planned a program of unusual value and interest. The morning program and luncheon, at the Civic Auditorium, will begin at 8:30 a. m. and luncheon will be served at 12:30. Speakers for the morning are Drs. Paul B. Magnuson, of Chicago; Harry E. Mock, Chicago; R. W. McNealy, Chicago; Russell M. Wilder, Rochester, Minnesota; E. Benjamin Gillette, Toledo; George L. Waldbott, Detroit; and Arthur E. Hertzler, Kansas City. The afternoon session, at the Civic Auditorium, will be addressed by Drs. Henry A. Christian, Boston; Frederick A. Coller, Ann Arbor; Charles A. Elliott, Chicago; Charles Lukens, Toledo; Reed M. Nesbit, Ann Arbor; and Plinn F. Morse, of Detroit. At 6:30 in the evening a banquet will be served at the Rumely Hotel, at which Dr. Charles P. Emerson, of Indianapolis, will be the principal speaker.

The American Association for the Study of Goiter will hold its annual meeting at Memphis, Tennessee, May 15, 16, and 17, 1933. There will be hospital and diagnostic clinics each morning, scientific discussions in the afternoons, and scientific-social meetings in the evenings. Speakers include Drs. R. S. Dinsmore, Cleveland; George E. Beilby, Albany, N. Y.; W. O. Thompson, Chicago; C. Alexander Hellwig, Wichita, Kansas; Harold L. Foss, Danville, Pa.; John deJ. Pemberton and J. M. McCaughan, Rochester, Minnesota; William Weston, Columbia, S. C.; A. G. McGhie, Hamilton, Ontario; C. H. Mayo, Rochester, Minnesota; Henry S. Plummer, Rochester, Minnesota; W. D. Haggard, Nashville, Tennessee; R. B. Cattell, Boston; Willard Bartlett, St. Louis; F. A. Coller and W. G. Maddock, Ann Arbor; Arthur E. Hertzler, Halstead, Kansas; Charles H. Frazier, Philadelphia; Benjamin Markowitz, Bloomington, Illinois; Martin Nordland, Minneapolis; James A. Lehman, Philadelphia; M. O. Shivers, Colorado Springs; Shelby W. Wishart, Evansville; Donald Guthrie, Sayre, Pennsylvania; Emil Goetsch, Brooklyn; Andre Crotti, Columbus; H. H. Searls and Wallace I. Terry, San Francisco; James A. Hill, Houston, Texas; S. J. Waterworth, Clearfield, Pennsylvania; and George W. Crile, Cleveland. Members of the profession in good standing are invited to attend the meeting. J. R. Yung, M. D., of Terre Haute, is the corresponding secretary for the Association.

WOMAN'S AUXILIARY

Interest of the Indiana Auxiliary members was centered this month on the March third meeting of the Woman's Auxiliary to the Indianapolis Medical Society because of the special program planned by its president, Mrs. William S. Tomlin. Honored guests were the officers of the State Auxiliary: Mrs. O. O. Alexander, Terre Haute, president; Mrs. I. N. Trent, Muncie, president-elect; Mrs. C. F. Voyles, Indianapolis, vice-president; Mrs. R. L. Compton, Osgood, recording secretary; Mrs. C. N. Combs, Terre Haute, corresponding secretary; Mrs. U. G. Poland, Muncie, treasurer; Mrs. F. W. Cregor, Indianapolis, press and publicity; Mrs. Joseph Weinstein, Terre Haute, organization; Mrs. E. D. Clark, Indianapolis, historian. Also present were Mrs. C. M. Mix, Muncie, president of the Delaware-Blackford Auxiliary; Mrs. F. B. Wishard, of Anderson, former president of the Madison County Auxiliary; and Mrs. Thomas A. Hendricks.

Dr. Joseph Weinstein, of Terre Haute, president of the Indiana State Medical Association, complimented the diplomacy of physicians' wives, then spoke seriously on "Medical Economics," explaining many of the controversial points in the report of the Committee on the Costs of Medical Care. Physicians' wives know of the high cost of plumbing, child-bearing, beauty culture, and legal advice; they know much of the expensively-acquired knowledge of their husbands is given to charity and to the patient who *intends* to pay *after* he has paid the butcher, the baker, the candle-stick maker, and the automobile salesman; they *should* know how this committee would herd the physicians into the narrow confines of bureaucracy; if necessary, they should be able to take an intelligent part in a discussion in their clubs, for club contacts are the most valuable assets of Auxiliary members.

A beautiful musical program was given by Miss Fannie Kiser, harpist, and Mrs. Lorinda Cottingham-Howell, violinist. Social arrangements were in charge of Mrs. D. O. Kearby and Mrs. O. G. Pfaff. Mrs. Hugo Pantzer and Mrs. Carl New assisted at the tea-table.

When giving your name to the Auxiliary, use your husband's initials, for you are eligible to membership in this organization through his membership in the Indiana State Medical Association.

As the Auxiliary is given one column (about 425 words) for news, please send in concise reports, for blue-penciling by strange hands sometimes disturbs continuity. Reports must be sent the first of the month as this copy must reach THE JOURNAL office on the tenth.

MRS. FRANK W. CREGOR, *Chairman*,
Press and Publicity Committee.
5220 No. Meridian St., Indianapolis

BOOK REVIEWS

THE HISTORY OF DERMATOLOGY. By William Allen Pusey, A. M., M. D., LL. D. Professor of Dermatology Emeritus, University of Illinois; Sometime President of the American Dermatological Association and of the American Medical Association. Octavo of 223 pages. Cloth. Price $3.00. Charles C. Thomas, Springfield, Illinois, and Baltimore, Maryland, 1933.

Dr. Pusey has selected from the voluminous literature of medical history the essentials of the history of dermatology. This particular field has long engaged the attention of mankind, for as Pusey says, "skin diseases obtrude themselves upon the attention in a way that few others do, and none of man's medical efforts can have been mueh earlier than those to relieve his itehing and to get rid of sores and scabs and parasites that afflicted his skin."

Beginning with the Ebers Papyrus, the development of dermatology has been traeed through the ages in a very interesting and easily readable form. The author has very wisely refrained from attempting to separate dermatology from internal medicine, for, as every dermatologist knows, the constitutional background is of exceeding importance in the proper interpretation of skin lesions. The work includes interesting biographies of Willian, Rayer, Sehönlein, Hebra, Ricord, and Jonathan Hutchinson. Of the modern dermatologists, Worcester, James White, Duhring, and Unna are especially emphasized.

By no means the least valuable part of the work is "An Historical Index of Dermatology," prepared at the suggestion of Dr. Pusey's associate, Dr. Herbert Rattner. While in no sense a complete bibliography of dermatology it cites an interesting list of valuable references.

* * *

SURGICAL CLINICS OF NORTH AMERICA. Vol. XIII, No. 1. Per clinic year, paper, $12; cloth, $16. W. B. Saunders Co., Philadelphia. February, 1933.

This volume of 247 pages is known as the Pacific Coast number in that the contributors are fellows of the Pacific Coast Surgical Association. The material is decidedly varied in scope and each article is brief and to the point, making the material, as a whole, very readable and very instructive. In no sense does this volume smack of a let-down in the standards already set up by the publishers of this series. The editors are to be complimented on their choice of material included in the volume.

* * *

PRACTICAL MEDICINE SERIES. 1932. Edited by George H. Weaver, M. D., Lawrason Brown, M. D., George R. Minot, M. D., William B. Castle, M. D., William D. Stroud, M. D., and Ralph C. Brown, M. D. 837 pages. Cloth. Priee $2.50. The Year Book Publishers, Chicago, 1932.

The 1932 series is published with the same high standards as before, and reviews the literature to date. The sections are abstracts of published articles in all the leading English and foreign journals. The chapters on infectious diseases and on diseases of the chest are made much more interesting by reason of the illuminating editorial notes in parentheses. Passive immunization for chickenpox, mumps, measles, etc., is stressed. The review on pulmonary tuberculosis brings out the point that early cases are "seen and not heard" and places much dependence on roentgenological examinations. Lawrason Brown has long held that change was the important thing in the treatment of pulmonary tuberculosis. Change even from a good climate to a poor one may bring stimulation. There is one article on hypertension abstracted from THE JOURNAL of the Indiana State Medical Association. This is a very handy compilation for quick reference, and serves to invite one to a more extensive reading.

THE COSTS OF MEDICINES. By C. Rufus Rorem, M. D., and Robert P. Fischelis, B. S., Phar. D. Publication of the Committee on the Costs of Medical Care, No. 14. 250 pages. Cloth. Price $2.50. The University of Chicago Press, Chicago, 1932.

This is the fourteenth of a series of fact-finding studies. It is a most exhaustive and detailed tabulation of all facts involved, both professional and commercial. A startling statement is that of the $715,000,000 spent annually for drugs, only $190,000,000 is spent under the direct advice of physicians, while the $525,000,000 represents self-medication. The manufacture and sale of drugs is rapidly passing from a profession to an industry and is due to mergers and chain organizations. An interesting table gives in parallel columns the same drugs with proprietary and official names, showing how the cost of the former is four times that of the latter. It is estimated that if physicians would prescribe official remedies only, the cost of an average prescription would decline from $1.25 to ninety cents. The volume is recommended to any one interested in the economic aspects of medical care.

* * *

FOOD IN HEALTH AND DISEASE. Preparation, physiological action and therapeutic value. By Katherine Mitchell Thoma, B. A., director of dietetics, Michael Reese Hospital, Chicago. 370 pages. Cloth. Price $2.75. F. A. Davis Company, Philadelphia, 1933.

This is a well-written, clear and concise text or reference book, especially for student nurses, as all unnecessary material is omitted. There is so much that can be included in a study of foods and nutrition that a text for nurses who have a limited number of hours to devote to it must be radically condensed and give only the essentials. This book meets this need. At the end of each chapter in the Diet and Disease section, diet outlines are given showing exactly what foods are allowed or forbidden for each diet. This is of great value not only to the nurse but also to the physician or dietitian, as this outline can be given to patients to follow at home. The subject of vitamins is presented in a way easily understood by the average lay mind and shows the dangers of faddism in diet. A person who coddles his food idiosyncrasies may be near the danger line of avitaminosis.

* * *

PROCEDURES IN TUBERCULOSIS CONTROL. By Benjamin Goldberg, M. D., F. A. C. P., associate professor of medicine, University of Illinois. Chapter on sanatorium planning by Thomas B. Kidner, and introduction by David J. Davis, M. D. 373 pages with 54 illustrations. Cloth. Price $4.00. F. A. Davis Company, Philadelphia, 1933.

This book has a limited appeal but is invaluable to a physician who wants to solve the tuberculosis problem in his city or county. It gives practical details for organizing and conducting tuberculosis dispensaries, hospitals and clinics. Unvarying is the advice to keep such affairs under the direct supervision and control of physicians and particularly to keep the private physician uppermost in the mind of the patient. The Mexican and negro problems are discussed in a most interesting manner. There is a chapter on sanatorium planning by Thomas B. Kidner, an acknowledged authority. A plea is made for the admission of tuberculous patients to general hospitals and the reasons given are convincing even to a most prejudiced hospital administrator.

* * *

PREVENTIVE MEDICINE. For Medical Practitioners and Students. Prepared under the auspices of the Committee on Public Health Relations, New York Academy of Medicine. Twenty-four contributors. Second edition, revised. 462 pages. Flexible binding. Price $5.00. Paul B. Hoeber, Inc., New York, 1932.

This book was prepared to serve a long-felt need by the Committee on Public Health Relations of the New York Academy of Medicine. It is a fine source book from which to crib lectures and talks, such as many physicians are called upon to present before parent-teacher meetings, clubs, and other lay groups. Quoting from Dr. Dana's foreword, "Prevention of disease involves at least two lines of action; one preventing the contraction of certain diseases, the other preventing the development of serious symptoms of the disease contracted." The book develops new fields in the realm of prevention, many of which have not yet struck in to the consciousness of the general practitioners. Dr. Sondern discusses the illegal practice of medicine by technicians and nurse anesthetists and urges legal regulation. We commend this outline very highly to all serious physicians who strive to educate their patients in the prevention of disease.

* * *

CHILDREN'S TONSILS IN OR OUT: A Critical Study of the End Results of Tonsillectomy. By Albert D. Kaiser, M. D., Associate Professor of Pediatrics, University of Rochester Medical School. 307 pages. Illustrated. Philadelphia and London. J. B. Lippincott Company, 1932. Price $5.00.

This book is attractively put up with a bibliography at the end of each chapter and a good index at the end of the book. The style is pleasing and the subject is one of interest and importance to every physician.

The author speaks with authority of the conditions where tonsillectomy may be expected to give valuable results and where it is of doubtful or of no advantage. The definite physiological merits of normal tonsillar tissue is discussed and likewise the menace of badly infected tonsils to the individual and to the community. The indiscriminate removal of tonsils as a cure-all is not countenanced. The relation of adenoids to tonsils is carefully considered. The benefits of needed adenectomy, alone or with tonsillectomy, is stressed. The bacteriology of the tonsils is discussed in relation to various diseases. The streptococcus hemolyticus is of greatest importance in frequency of disease production.

The study is based on a ten-year observation of 4,400 children, 2,200 of whom had tonsillectomies. After a ten-years' follow-up study of these children the author concluded that after tonsillectomy good results are evident only in reduction of sore throats, cervical adenitis, otitis media, scarlet fever, diphtheria, rheumatic fever and heart disease.

About 35% of children are subject to repeated attacks of sore throat or tonsillitis during childhood. Removal of tonsils in these offered a 75% chance of protection against sore throat, while where not removed there was a natural decline with normal body growth of 15%. Acute colds and otitis media were lessened for a three-year period after tonsils were removed but there was not much difference after this. A slight beneficial effect from tonsillectomy was observed in the incidence of scarlet fever but there was a definitely lessened susceptibility to diphtheria. It is, of course, of especial value in carriers. The respiratory infections were not benefited and perhaps actually became more frequent after tonsils were removed.

A chapter considers the hazards of tonsillectomy and another the possible indications for electro surgery. The inability of dealing with the adenoids is one factor making electro surgery unsatisfactory. A chapter warns against incomplete and careless removal of tonsils.

* * *

OFFICE SURGERY. By Fenwick Beekman, M. D., Clinical Professor of Surgery, New York University and Bellevue Hospital Medical College. 402 pages with 94 illustrations. Flexible binding. Everyday Practice Series, edited by Harlow Brooks, M. D. J. B. Lippincott, Philadelphia and London, 1932.

The author has written this book according to his introductory remarks, with the idea of putting the common run of surgery in a readable style and form.

The book is divided into sixteen chapters, and contains 387 pages. It covers a large field in a superficial way. The author pertinently remarks that there is no minor or lesser surgery and recommends that any type of surgery be done under hospital conditions. The information contained in the book is based upon the wide knowledge and experience of the author which he has gained from his extensive work, but it is the opinion of the reviewer that a book of this type would be of greater value to a medical student than to a man in office practice. The man in active practice,

whatever his requirements may be in handling a case, either from the standpoint of diagnosis or treatment, would most certainly employ a book with more elaborate information. The book contains material of great value and will interest any physician.

* * *

MENTAL DEFICIENCY DUE TO BIRTH INJURIES. By Edgar A. Doll, Ph. D., Director of Research, the Training School at Vineland; Winthrop M. Phelps, M. D., Professor of Orthopedic Surgery, Yale University; and Ruth Taylor Melcher, M. A., Research Assistant, Vineland. 289 pages. Illustrated. Price $4.50. The MacMillan Company, New York, 1932.

This book is an important addition to the literature of the difficult to deal with, and often neglected, condition of mental deficiencies more or less directly traceable to injuries of the central nervous system apparently resulting from birth. It is an attempt at a better approach to the mental capacity of these patients by improvement of their motor handicaps which make expression for them more or less impossible. It is a "neuro-physiological experiment for studying the relation of behavior to cerebral integrity."

"The major problems of the investigation have been (a) to describe the consequences of birth injury as related to mental deficiency and motor handicap, (b) to develop more exact methods of mental measurement of birth-injured mental deficient subjects, (c) to evaluate the mental and physical benefits which may be expected from physical therapy, especially motor re-education, and (d) to formulate some of the theoretical implications suggested by this condition."

The motion picture is tried as a method of recording motor development. The Stanford-Binet mental test proved the most successful of nine standard tests tried.

At Vineland six per cent of the patients were considered as belonging to the class here studied. The book gives in detail the study of twelve cases, nine boys and three girls, of ages from four to thirty-nine years.

There is a review of the literature of the subject and a chapter on the etiology. A good bibliography is included.

This book should be of especial interest to the obstetrician, pediatrician and neuro and orthopedic surgeon.

* * *

YOUR TEETH AND THEIR CARE. By Carl W. Adams, D. D. S., San Bernardino, Calif. 137 pages. Illustrated. Price $1.25. The C. V. Mosby Company, St. Louis, 1932.

The subtitle of this book is, "A simple explanation of dentistry, dental procedures, and the relation of the dentist to the public."

The book gives the anatomy, development and function of the teeth. It discusses irregularities of teeth which may result in malocclusions. Diseases of the teeth and oral mucous membranes are discussed from the viewpoint of cause, and oral prophylaxis is recommended under the guidance of the dentist. There is a chapter on diet in relation to oral health. The reasons for the ordinary dental procedures are explained. It is a concise, instructive book for the lay person interested in teeth and how to keep them.

* * *

INJURIES OF THE EYE. By Harry Vanderbilt Wurdemann, M. D., Sc. D., F. A. C. S., Colonel Medical Res.; Flight Surgeon, Air Corps, U. S. Army; Medical Examiner, Aeronautic Branch, U. S. Department of Commerce, Seattle, Washington. Second edition, 917 pages. 235 illustrations with 8 color plates. Cloth. Price $13.50. C. V. Mosby Company, 3525 Pine Boulevard, St. Louis, Mo.

This book is based chiefly on the author's personal experience in special practice, covering a period of forty-two years. While the book is intended more for the ophthalmologist, it will prove of great interest and value to the general practitioner. The subject is presented from the practical, clinical and therapeutic standpoint. The text is adequately illustrated with excellent drawings and photographs, made by the author. Part III, dealing with the medicolegal aspects of eye injuries, pensions, accident insurance and visual economics, is of especial interest to the physician doing industrial work.

Books received since March 1, 1933:

THE MEDICAL SECRETARY. By Minnie Genevieve Morse, member of the Board of Registration, Association of Record Librarians of North America. 162 pages. Cloth. Price $1.50. The Macmillan Company, New York, 1933.

CLINICAL DIAGNOSIS. Physical and Differential. By Neuton S. Stern, A. B., M. D. (Harvard), Associate professor of Medicine, University of Tennessee School of Medicine. 364 pages. Cloth. Price $3.50. The Macmillan Company, New York, 1933.

DISEASES OF THE HEART. By Sir Thomas Lewis, C. B. E., F. R. S., M. D., physician in charge of department of clinical research, University College Hospital, London. 297 pages. Cloth. Price $3.50. The Macmillan Company, New York, 1933.

CRITERIA FOR THE CLASSIFICATION AND DIAGNOSIS OF HEART DISEASE. By the Criteria Committee of the Heart Committee of the New York Tuberculosis and Health Association, Inc. Approved by the American Heart Association. Third edition. 131 pages. Illustrated. Cloth. Published by the New York Tuberculosis and Health Association, New York, 1932.

PRINCIPLES AND PRACTICE OF OBSTETRICS. By Joseph B. DeLee, A. M., M. D., Professor of Obstetrics and Gynecology at the University of Chicago; Chief of Obstetrics, Chicago Lying-In Hospital and Dispensary; Consulting Obstetrician to Provident Hospital, to the Chicago Maternity Center, etc. Sixth Edition, Thoroughly Revised. 1165 pages with 1221 illustrations on 923 figures, 265 of them in colors. Philadelphia and London. W. B. Saunders Company, 1933. Cloth. $12.00 net.

THE SURGICAL CLINICS OF NORTH AMERICA. (Issued serially one number every other month.) Volume 13, No. 1. (Pacific Coast Surgical Association Number—February, 1933.) 247 pages with 90 illustrations. Per Clinic Year (February, 1933, to December, 1933) Paper, $12.00; Cloth, $16.00 net. Philadelphia and London. W. B. Saunders Company, 1933.

THE PELVIS IN OBSTETRICS. A Practical Manual of Pelvimetry and Cephalometry, Including Chapters on Roentgenological Measurements. By Julius Jarcho, M. D., F. A. C. S., consulting gynecologist, Hastings Hillside Hospital. 365 pages. 140 illustrations and 51 tables. Cloth. Price $6.00. Paul B. Hoeber, Inc., New York, 1933.

SOCIETIES AND INSTITUTIONS

INDIANA STATE MEDICAL ASSOCIATION EXECUTIVE COMMITTEE

January 22, 1933.

Meeting called to order at 12 o'clock noon.

Roll call showed the following present: W. H. Kennedy, M. D., chairman; H. H. Wheeler, M. D.; J. H. Weinstein, M. D.; O. O. Alexander, M. D.; E. E. Padgett, M. D.; A. F. Weyerbacher, M. D.; Albert Stump, attorney, and T. A. Hendricks, executive secretary.

The bills for December and January were approved for payment.

The monthly statement of receipts and expenditures in December and the report of the budget for December were presented.

Final Membership Report for 1932

Number of members December 31, 1931	2,766
Number of members December 31, 1932	2,720
Loss in 1932	46

1933 Membership Report

Number of Members January 21, 1932	773
Number of members January 21, 1933	1,020
Gain	247

Return of Coupons on State Highway Aid Bonds of Lake County

Note received from the Indiana National Bank stating that Lake County, Indiana, coupons deposited January 5 in the

amount of $50.00 had been returned to the bank unpaid because funds were not available at this time for payment.

Exhibit Space Unpaid for

William H. Armstrong Company still owes $45.00 on 1931 account.

1933 Convention

(1) Assistant to director of scientific exhibit. The committee authorized Dr. Ernest Rupel to appoint an assistant to take care of the moving picture program at the 1933 convention.

(2) Contract with French Lick Springs Hotel. The secretary was instructed to ask Dr. Dillinger if the French Lick Springs Hotel could be persuaded to take care of outstate guest speakers gratis, as several members of the committee were of the opinion that this is a customary practice of the hotels.

(3) Medals to ex-presidents. The secretary was instructed to obtain a list of living past presidents in order that medals similar to those which have been presented to the last two presidents may be presented to them. This list is to be presented at the next meeting of the Executive Committee, along with the estimated price for such medals. (Die for these medals already has been made and used in making the medals presented to Dr. Graham and to Dr. Crockett.)

Admission of Patients to Riley Hospital

Dr. Kennedy reported a plan by Dr. D. O. Kearby in regard to the forms which should be made out before a patient is admitted to the Riley Hospital. The committee instructed Dr. Kennedy to see that Dr. Kearby took up the matter with Dr. W. P. Garshwiler, chairman of the Public Relations Committee. A report upon this plan should be made at the next meeting of the Executive Committee.

Suggestion in Regard to Report of Committte on the Costs of Medical Care

A letter from Dr. F. S. Crockett was read to the committee, containing the following suggestion as to how the majority report of the Committee on the Costs of Medical Care might be attacked by the medical profession:

"It would seem to me that the members of the profession should be advised concerning what the thing was all about and to be instructed as to proper and legitimate answers to the recommendations of the majority report since we all seemed to be against the majority report. The fear seemed to be that someone might call a public meeting and create a sentiment in the public for some such thing. Later I heard (by the grapevine route) that some woman in some local club arose in great fervor and alarm and announced that doctors, dentists, etc., had had a meeting and had resolved to do no more charity work and were going to try to put over a plan by which the community would be compelled to pay for all medical care.

"I think perhaps that was the best news that we could get. It is possible that the medical profession shouldn't fight this plan of the majority report directly. It might be wise if we would get up and say we were through doing all this charity work for nothing; that we were determined to be paid for it; that it was going to increase taxes like the dickens, but we had decided it would be all right to do that; that everybody else was on the public payroll and was being paid and it was time the medical profession also was being paid. I think if we made a few speeches like that in the county here, or any other county in the state, that an indignant citizenry would rise up and defeat anything we might suggest toward the socialization of medicine, as you know, very much to our delight. I can just see the Taxpayers Union jump on such a plan sponsored by the doctors selfishly to be paid for work done which they should do for nothing. If we fight the socialistic idea, it might create the impression on the public that 'there was a nigger in the wood-pile somewhere' and they had better go in for the socialization of medicine."

Fees in Coroner's Cases

A request was made relative to the fee for autopsy held under coroner's orders, and Lawrence F. Orr, state examiner of the State Board of Accounts of Indiana, answered the inquiry as follows:

"The statutes do not provide for such fee. The general practice over the state is to charge a $25.00 fee when such autopsies are held."

Membership in Parke-Vermillion and Vigo County Medical Societies

Letter from A. M. Mitchell, M. D., secretary of the Vigo County Medical Society, in regard to physicians practicing in Parke and Vermillion counties desiring membership in the Vigo County Medical Society, brought to the attention of the committee. The committee referred the matter to Dr. O. O. Alexander, councilor of the fifth district, in which these counties are located.

Ripley County Society Action Against Certain Doctors

A protest of the Ripley County Medical Society against certain doctors who came into Ripley County and gave diphtheria toxoid in a school immunization program which the Ripley County Medical Society had disapproved, brought to the attention of the committee. The committee postponed action until it receives a report upon this matter from Dr. Graessle, councilor for the district in which Ripley County is located. The secretary was instructed to obtain an official report upon developments from the councilor by the next meeting of the Executive Committee.

Picture of Dr. Bulson

The Executive Committee instructed the secretary to obtain a picture of the late Dr. A. E. Bulson, the founder and for twenty-five years the editor of THE JOURNAL, and have it hung in THE JOURNAL office.

Letter from the American Society for the Control of Cancer

The following letter was received:

"Many thanks for your letter of December 9 advising that your State Council was not ready for a cancer survey in Indiana.

"I rather sensed this outcome of our offer to make this survey after hearing the discussion of my remarks at your luncheon meeting. No matter how hard you try, it is difficult to convince some people of your sincerity and desire to be of help in a situation that is causing much concern to them. I only hope that your Society will not be faced with the necessity of combating efforts by other groups to take from your members the control of the cancer problem in your state.

"I appreciate very much your luncheon invitation and the opportunity to place before the Council of your State Society the policies of the American Society for the Control of Cancer at your recent meeting.

"I will be very glad to keep in touch with you regarding developments in Indiana, and if I can serve you at any time, please let me know."

Contract Practice and Group Hospitalization

(1) *The Fellowship Hospitalization Fund of Methodist Hospital.* Condemned by Executive Committee. The "Membership Agreement" of the Fellowship Hospitalization Fund of the Methodist Hospital was brought to the attention of the Executive Committee, along with a statement adopted by the staff committee of the Methodist Hospital pertaining to group hospitalization. The Executive Committee went on record highly commending the statement adopted by the staff committee, pointing out the demoralizing influence of contract practice and group hospitalization. The committee condemns group hospitalization in principle and the Methodist Hospital of Indianapolis for adopting a plan of group hospitalization which is not in keeping with the report of the staff committee, the sense of which report was against group hospitalization.

It was moved by Dr. Weinstein, seconded by Dr. Alexander, that information in regard to the action of the Executive Committee condemning this fellowship plan be sent to the superintendent of the Methodist Hospital, the chairman of the Board of Trustees, the president of the staff; Dr. William C. Woodward, director of the Bureau of Legal Medicine and Legislation of the American Medical Association, and Dr. Olin West, secretary and general manager of the American Medical Association. The formal resolution follows:

WHEREAS, The Indiana State Medical Association is against group hospitalization in principle because of its inherent possibilities of detriment to the public, hospitals, and the medical profession; and,

WHEREAS, The Fellowship Hospitalization Fund Plan of the Methodist Hospital of Indianapolis is not in keeping with the very comprehensive and thorough report of the staff commit-

tee of the Methodist Hospital against group hospitalization; therefore, be it

Resolved, That the Executive Committee of the Indiana State Medical Association condemn group hospitalization in principle and condemn the Methodist Hospital of Indianapolis for adopting a plan which is in its essence group hospitalization, and that the Exectuive Committee heartily commend the staff of the Methodist Hospital upon its splendid statement on this subject, and that copies of this resolution be sent to:

Dr. John G. Benson, Superintendent, Methodist Hospital.

Mr. Arthur V. Brown, Chairman, Board of Trustees.

LaRue Carter, M. D., President of Staff.

William C. Woodward, M. D., Director, Bureau of Legal Medicine and Legislation, American Medical Association.

Olin West, M. D., Secretary and General Manager, American Medical Association.

(2) *Opinion of Attorney General.* The Attorney General has given the following opinion in regard to the right of a hospital to engage in an insurance scheme for group hospitalization:

"I have before me your request for an opinion as follows:

" '———— Hospital, a secetarian institution organized not for profit under the laws of the State of Indiana, under Section 19 of the Acts of 1895 and Section 21 of the Acts of 1901, with a "purpose clause," amended by authority of these acts in 1899, providing as follows:

" ' "The objects of this association are to establish and maintain a hospital or hospitals for the treatment of the sick, wounded and injured persons, and to dispense relief and charity to the poor and destitute and to maintain a school for the education and training of nurses."

" 'Is proposing to establish a plan for hospitalization "for its employees, students and graduate nurses of its training school, staff members, trustees, ministers and organization workers of the ———— Hospital of Indiana." Their plan is to offer each person, of the above class, room and board and certain hospital service in the hospital for not exceeding three weeks in the year 1933 upon payment to the hospital of the sum of $9.00 at the beginning of the year by each person desiring to accept.

" 'I desire to know whether such a plan constitutes insurance of a character over which the Insurance Commissioner is required to exercise supervision and to require such an institution to comply with the laws of the State of Indiana conernning insurance companies.'

"From a consideration of the hospital's plan as outlined in your letter, it appears that the hospital undertakes for a consideration of nine dollars, paid at the beginning of the year, to make available a room in its hospital and certain hospital service, if required, not exceeding three weeks, within the ensuing year. This privilege is open to employees and others apparently having some connection with the institution.

"I do not find in this arrangement the elements of an indemnity contract. It is rather a special contract by the hospital for the limited use of the privileges afforded by the hospital if needed by employees and others, who on account of their relation to the institution, have some claim to special consideration. This is not an insurance contract, it is a conditional contract for service.

Hensel v. Provident Bicycle Assn., 178 Pa. 636;
Beck v. Pennsylvania R. R., 63 N. J. L. 241, 76 Am. State Reports 211.

"I am of the opinion that ———— Hospital is not conducting an insurance business, when it uses the plan outlined in your letter; that the Insurance Commissioner is not required to supervise or regulate its operation in that respect."

Dr. Woodward of the A. M. A. comments as follows upon this opinion of the Attorney General:

"I thank you for your letter of January 18, enclosing, in response to my request, a copy of the opinion of the Attorney General in which it was held that a hospital might guarantee certain medical, nursing, and hospital services for persons officially connected with that establishment, without the guarantee coming within the provisions of the insurance laws of the State of Indiana.

"The fact that the hospital undertakes to guarantee the services described only to persons officially connected with the institution gives this situation a new slant. I shall study it, not with a view to changing the situation in the State of Indiana, but with a view to being prepared to advise our associations in other states concerning this plan."

(3) *Health Insurance.* Periodic payment plan for medical care of wage-earners, as adopted by California State Medical Association, brought to attention of committee.

Request for Refund of JOURNAL *Subscription.* Letter received by committee stating that three physicians who have office together want to take one copy of THE JOURNAL, and they ask for a refund of the other two subscriptions. The committee said that such a refund would be absolutely contrary to the Constitution and By-Laws of the State Association.

Malpractice cases were reported upon.

Question in Regard to Testimony in Malpractice Suits

The following letter was received at the headquarters office:

"We have been defending some doctors in malpractice cases and have been told that there is in effect in the medical societies, rules to the effect that members of the medical societies in good standing will testify in malpractice suits without charge.

"Inquiries of local doctors bring the answer that they know of no such rule and we have been directed to write to you.

"Will you please tell us whether there is such a rule?"

None of the members of the committee knew of any such agreement. The members of the committee, however, were of the opinion that unquestionably there is a courtesy understanding among the members of the profession by which many physicians gladly assist their fellow practitioners without charge, but this is entirely up to each individual man in each individual case to use his own pleasure.

Abstract of Medicolegal Cases

Volume prepared by the American Medical Association. Purchase authorized by the committee.

There being no further business, the meeting was adjourned.

INDIANA STATE BOARD OF HEALTH
DIVISION OF COMMUNICABLE DISEASES
MONTHLY REPORT, FEBRUARY, 1933

Current prevalence of the more common reportable diseases as indicated by the reports of health officers, physicians and institutions of the state show a decline as compared with the previous month except measles, scarlet fever and typhoid fever. There were 2,487 cases of disease reported, 4,207 cases the preceding month and 3,255 cases the corresponding month the previous year. Every county in the state reported either positive or negative. Reports were sent in from cities of 5,000 population and over, except Vincennes and Clinton. Nine hundred fifty-one negative report cards were received.

MEASLES. Seventy-three cases of measles were reported the current month, 53 cases the previous month and 408 cases the corresponding month the preceding year. A low level for the disease is shown. February marks the beginning of measles time. The estimated expectancy was 1,579 cases. The estimated expectancy is based on the experience of the last seven years.

SCARLET FEVER. There is very little change in the prevalent incidence (554 cases) of scarlet fever during the month as compared with the previous month, when 511 cases were reported. There were 541 cases reported the corresponding month the preceding year. The estimated expectancy over a seven-year period for February is 967 cases.

TYPHOID FEVER. The number of cases (13) of typhoid fever indicates the low level of prevalency for the disease at this season of the year. Ten cases were reported the previous month and fourteen cases the corresponding month the preceding year. The estimated expectancy for February is eleven cases. The estimate is based on the seven-year period mentioned above.

MENINGOCOCCUS MENINGITIS. The reported incidence of meningococcus meningitis shows a favorable low level for the season. Seven cases reported this month, eighteen cases last month and thirty cases the corresponding month the previous year. The disease has been epidemic for the last three years,

especially in Marion County. Six of the current cases were reported from Marion County and one case from St. Joseph County.

DIPHTHERIA. A very favorable decline is shown in diphtheria. The current number is 160 cases, 226 cases the previous month and 237 cases the corresponding month the preceding year. The normal average for February during the last five years is 161 cases.

SMALLPOX. The prevalent incidence of smallpox (7 cases) is the least number of cases reported in February in the history of the division. Twelve cases were reported last month and 76 cases the corresponding month last year. The average number of cases in February for the last seven years is 431 cases.

INFLUENZA. The reported incidence of influenza (414 cases) indicates the epidemic is rapidly declining. There were 2,431 cases reported the previous month, 5,118 cases reported in December of last year and 400 cases in February of last year. Ninety per cent of influenza cases are reported from the rural population. The larger cities of the state do not report their cases of the disease.

The name and number of diseases not mentioned above reported during the month are as follows: Tuberculosis, 229; chickenpox, 593; whooping cough, 136; pneumonia, 79; mumps, 206; poliomyelitis, 3; trachoma, 1; undulant fever, 4; septic sore throat, 5 cases, and one case each of erysipelas and gas bacillus infection.

H. W. MCKANE, M. D.,
Collaborating Epidemiologist, Indiana State Board of Health.

TWENTY-NINTH ANNUAL CONGRESS ON MEDICAL EDUCATION AND LICENSURE

February 13 and 14, 1933, Chicago

Report of the Chairman of the Council on Medical Education and Hospitals of the American Medical Association. Ray Lyman Wilbur, M. D., Washington, D. C. Dr. Wilbur in his report stated there is a 25 per cent surplus of approved hospitals for internship. There is an over-supply of physicians in the United States and several times more applicants than can be trained. There are 2,000 Americans in European medical schools. Many untrained specialists are imposing on the public and regulatory measures are imperative.

Note: The assembly passed a resolution asking the Council on Medical Education of the American Medical Association to adopt standards of qualification of specialists after meeting with representatives of the specialists. A list of qualified specialists to be published later by the American Medical Association.

Results of the Work of the Commission on Medical Education. Samuel P. Capen, Ph. D., Chancellor, University of Buffalo. Dr. Capen praised the methods of the A. M. A. Council on Education which has raised the standards of medical education by grading the quality of medical schools. The number of schools and students have been reduced 50 per cent. Other college groups have adopted the same methods and a general reform of professional schools has been brought about by the A. M. A. Council plan.

There has been a stupendous increase in the cost of medical education. Methods of medical education will have to be constantly recast and readjusted with progress.

Medical Education Abroad. Alan Gregg, M. D., Director, The Medical Sciences, The Rockefeller Foundation, New York. Dr. Gregg discussed medical education abroad. He spent seven years in Europe observing their medical methods. Europe has three times our population and half the area of the United States. United States has the greatest density of physicians per population of any country in the world.

In Europe medical graduates must spend from five to fifteen years as assistants before establishing themselves. If they try to accelerate their progress they will tread on the heels of those ahead and if they lag behind they are submerged by the oncoming horde.

Comments on the Internship. Willard C. Rappleye, M. D., Dean, Columbia University College of Physicians and Surgeons, New York. Dr. Rappleye commented on internships. Seventeen states require internships for graduation and licensure. The best appointments are obtained by the best students. Only 10 per cent of patients are hospitalized and increased outpatient departments are needed.

The Function of Special Boards of Examiners. Sanford R. Gifford, M. D., Chicago. Dr. Gifford spoke on the function of special boards of examiners. He praised the work of the American College of Surgeons and stated that it has a membership of 11,000 out of 40,000 surgeons. He suggested that specialist members of hospital staffs should be restricted to members of special societies.

The Function of Medical Schools. Irving S. Cutter, M. D. Dean, Northwestern University Medical School, Chicago. Dean Cutter stressed the value of interne residency as specialists training. There are now 300 fellowships in American medical schools and these run three to five years. There are three times more applicants than positions. If there were more two-year internships there would be less need for specialists. The medical profession must inform the public of qualified specialists.

The graduate school of the future should be a residency in a qualified hospital under medical school supervision.

Dr. Louis Wilson, of Rochester, Minnesota, suggested that each specialty have its own qualifying board and that a representative of each specialty should be on the national examining board.

Dean Lewis thought the public would pick the doctor they liked, no matter what his qualifications.

Dr. W. T. Coughlin, of St. Louis, spoke on "Research in Medical Schools." He stated that a widely-known research man is as valuable to a university as a winning football team. The ideal research man should be also a teacher and administrator.

Dr. Lewellys Barker commented on the majority report of the Committee on the Cost of Medical Care. The plan of medical practice must change with the present and future needs. Group practice centered around the hospital is the dominant note. No country has given up the health insurance plan after adopting it. Violent opposition by the medical profession in foreign countries lost the good will of the public, and legislation was passed without medical influence. He thinks some plan of health insurance and group practice is sure to develop in this country and that leading medical thought should mold such legislation. He admitted that group health insurance in foreign countries has not decreased mortality rates and has increased incidence of disability.

Dr. Alphonse Schwitalla, Dean of St. Louis Medical School, spoke for the minority report of the Committee on Cost of Medical Care. He stated that medicine in the last fifty years has made the greatest scientific advancements of any profession. This has been accomplished without lay interference or advice. The individual relationship between physician and patient cannot be assumed by a group. The direction of future trends of medicine must be kept in the hands of the profession.

Big business with their vaunted efficiency methods and mass production are mostly in the red and not so sure their methods are correct.

Dr. R. G. Leland, Director of the Bureau of Medical Economics of the A. M. A., spoke on prepayment for hospital care. He stated that only 10 per cent of the American hospitals are operated for profit. A large percentage of hospitals were over-built during prosperous times, and now have difficulty in meeting their overhead. Dr. Leland has traveled over the country and examined various schemes of group hospital insurance and found most of them are promoted by laymen. The promoter's commission varies from 21 to 75 per cent of the fees. The fee varies from $6.00 to $24.00 per year. The plan increases control of lay organization and causes deterioration of service and ethics.

Does the public need an increased amount of hospital care or more medical care in the home?

Dr. Morris Fishbein stated that the majority report of the Committee on the Cost of Medical Care was publicized by a $10,000 publicity agent and put before luncheon clubs all over the country before it was published.

Respectfully submitted,
J. H. STYGALL, M. D.

CLINTON COUNTY MEDICAL SOCIETY

The Clinton County Medical Society met March second, at 5:30, with Drs. S. B. Sims, M. F. Boulden, H. R. Royster, W. C. Mount, C. B. Compton, C. A. Robison, R. A. Hedgecock, J. A. Vankirk, A. G. Chittick, John S. Ketcham, and I. E. Carlyle present. Guests were Drs. L. D. Carter, J. M. Cunningham and Arthur Held.

Dr. L. D. Carter, of Indianapolis, presented a paper on "Brain Hemorrhage" and discussed some of the newer forms of intracranial bleeding. At the close of this paper Dr. Cunningham discussed "Appendicitis."

The meeting was well attended; papers and discussions were well received.

The Clinton County Medical Society is using a new plan of providing for papers. With twenty-two members and ten meetings, at each meeting two members are permitted to select speakers for the ensuing meeting. The president and secretary do not participate in the selections.

Respectfully submitted.

IVAN E. CARLYLE, M. D., *Secretary.*

ELKHART COUNTY MEDICAL SOCIETY

Elkhart, Ind., February 18, 1933.

Fifty-four members of the Elkhart County Medical Association met Thursday evening, February 17th, at Hotel Elkhart for a banquet honoring five members of the society. The members so honored because of their years of service in the medical profession were Drs. F. N. Dewey, C. W. Frink, and I. W. Short, of Elkhart; and Drs. C. L. Dreese and W. B. Kreider, of Goshen. Dr. Dreese was unable to attend because of illness.

Dr. J. A. Work acted as toastmaster, and after giving several reminiscences concerning older members of the society, presented the honor guests, each of whom in turn responded with a short talk.

Dr. J. C. Fleming made a speech, and in behalf of the society presented each of the honor guests with an appropriate gift.

Cards and a social time were enjoyed during the remainder of the evening.

S. T. MILLER, M. D., *Secretary.*

HANCOCK COUNTY MEDICAL SOCIETY

January 12, 1933.

We, the Committee, authorized by the President of The Hancock County Medical Society, to draft Resolutions of Respect in memory of Dr. Irvin W. Trees, who answered his final call December 30, 1932, offer the following:

Whereas, An All-Wise Providence has called from our midst a brother physician, an honorary life member of our County Society, a charter member of the Shelby County Society, and long valued practicing physician of this county; and

Whereas, There comes to us the realization of a long life spent in relieving the sick and needy, assisting his fellow men in every way possible within his power, and exemplifying the principles, practices, ethics and virtues of the Doctor of the Old School;

Therefore be it

Resolved, That we extend our sympathy to the daughter and other members of the family and relatives left to mourn his absence.

Resolved, That we recognize his loyalty and faithfulness to the practice of his profession, and as fellow physicians we will emulate his virtues and high standard of service.

Resolved, That these resolutions be spread upon the minutes of our society, and also a copy sent to the bereaved daughter.

CHARLES TITUS,
S. W. HERVEY,
JOSEPH L. ALLEN.

THE LAKE COUNTY MEDICAL SOCIETY

March, 1933

The regular meeting of the Lake County Medical Society was held at St. Margaret's Hospital, Hammond, Thursday, March 9, 1933, Dr. G. M. Cook presiding in the absence of President Jones.

The minutes of the February meeting were read and approved.

The chairman of the Legislative Committee reported as to legislation affecting the medical profession during the session only recently closed.

Application from Dr. Carl H. Bendler, of Gary, presented and referred to the Council.

The scientific program was presented by the staff of St. Margaret's, concluding with a movie from the Johns Hopkins Laboratories. The staff discussion was confined to the Leukemias, three types being discussed, with case presentations.

Dr. Ray Elledge gave a comprehensive study of the general subject; the internes staff discussed various phases of the subject and presented the cases and case histories; Dr. Skrentny also discussed various phases of the general subject, while Dr. Rauschenbach talked on the X-ray management of these cases.

In addition, Drs. Cook, Forester and Rhind, who had had charge of the three cases presented, talked on various aspects of their respective cases.

Adjourned.

E. S. JONES, *President.*
E. M. SHANKLIN, *Secretary.*

ST. JOSEPH COUNTY MEDICAL SOCIETY

The St. Joseph County Medical Society held its first dinner meeting for the year at the Oliver Hotel, Wednesday, January 25, 1933, with President Graham in the chair, and fifty members and nineteen guests from outlying towns present.

Doctor Clarence Neymann, of Northwestern University, spoke on "Diagnosis and Treatment of the Neuroses." The paper was discussed by Drs. Gladys Frith, Harmon, Wygant, Sensenich, Hoffman and one guest from Elkhart.

The meeting adjourned at 10:30 p. m.

The St. Joseph County Medical Society met in the Medical Room of the Public Library, Tuesday, January 31, 1933, at 8:30 p. m., with President Graham presiding, and forty-nine members present.

The society decided to honor Dr. H. T. Montgomery, now over eighty, by paying for his subscription to the Journal of the Indiana State Medical Association that he might become an honorary member of the Indiana State Medical Association.

Dr. Birmingham brought to the attention of the society that St. Joseph Hospital had been besieged by an insurance company with a scheme which looked like another get-rich-quick affair without ethics; also that the hospital was not interested.

Dr. Lent, chairman of the Public Health and Legislative Committee, reported the activities of his committee as regards the Chiropractic Bill; also Dr. Sensenich, a member of this same committee who had just returned from Indianapolis, reported on the bills before the Indiana Legislature explaining how the doctor would be affected by their passage, namely: the chiropractic bill, reorganization bill and, most vicious of all, the sales tax of 2 per cent on gross business.

The subject for the evening was Industrial Surgery. The speakers were: Mr. Chester D. Ihrig, from the viewpoint of the insurance company; Dr. J. W. Hilbert and Dr. K. E. Selby, from the viewpoint of the employer; Dr. I. Sandock, from the viewpoint of the physician.

Dr. Sensenich was appointed to draft a letter expressing the society's views on the sales tax of 2 per cent, such letter to be placed in the hands of Mr. Fred Weidman for the Legislature.

The meeting adjourned at 10:45 p. m.

The regular meeting of the St. Joseph County Medical Society was held in the Medical Room of the Public Library, Tuesday, February 7, 1933, at 8:30 p. m., Dr. Graham presiding. Thirty-one members were present.

The application of Dr. C. M. Malstaff for membership in the society was read and turned over to the Board of Censors.

A symposium on Gonorrhea was presented by the following doctors:

Dr. C. C. Hyde—Acute Gonorrhea.

Dr. E. Blackburn—Female Gonorrhea.

Dr. Buechner—U. S. P. H. S. Clinic.

Dr. P. C. Traver—Chronic Gonorrhea with Complications.

The papers were discussed by Drs. Marcus Lyon, Wygant, and Graham.

Dr. Sensenich reported on the progress of the chiropractic bill and the sales tax of 2 per cent on gross. The outlook was not propitious for the latter as the Legislature might camouflage it under the new name of tax on gross income, which meant the same thing.

Meeting adjourned at 10:30 p. m. after Dr. Cassady had announced that the next meeting would be a dinner, with Dr. Greenhill, of Northwestern University, as the speaker.

The St. Joseph County Medical Society held a dinner meeting in the Rotary Room of the Oliver Hotel, February 15, 1933, at 7 p. m., with President Graham in the chair. There were 43 members and 17 guests for the dinner, and ten other members came later for the talk.

Dr. J. P. Greenhill, from Northwestern University, spoke on "Recent Progress in Obstetrics and Gynecology." This was followed by four reels of motion pictures on Breech Presentation.

Questions asked by Dr. Fleming, of Elkhart, and Dr. Traver and Dr. Allen, of South Bend, were answered and discussed by Dr. Greenhill in closing.

Meeting adjourned by 10:30 p. m.

Martha Bewer Lyon, M. D.,
Assistant Secretary and Treasurer.

TRUTH ABOUT MEDICINES

NEW AND NON-OFFICIAL REMEDIES

The following products have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association for inclusion in New and Nonofficial Remedies:

Diphtheria Toxoid—U. S. P.—A diphtheria toxoid (New and Nonofficial Remedies, 1932, p. 370) prepared from diphtheria toxin whose L ⊥ dose is 0.2 cc. or less by treatment with formaldehyde. The product is standardized to contain in 2 cc. enough of the toxoid for one immunization treatment. It is marketed in packages of two 1 cc. vials; in packages of twenty 1 cc. vials; in packages of one 6 cc. vial; in packages of one 20 cc. vial; and in packages of one 30 cc. vial. United States Standard Products Company, Woodworth, Wis.

Maltine with Mineral Oil and Cascara Sagrada.—A mixture of liquid petrolatum (New and Nonofficial Remedies, 1932, p. 245), 40 cc., and Maltine (New and Nonofficial Remedies, 1932, p. 273), 60 cc., containing a nonbitter extract of cascara sagrada representing 2.2 Gm. of cascara sagrada per 100 cc. The Maltine Co., Brooklyn, N. Y. (*Jour. A. M. A.*, February 11, 1933, p. 411.)

Sterile 5% Dextrose Solution in Vacoliter Container.—Each 100 cc. contains dextrose, U. S. P. (New and Nonofficial Remedies, 1932, p. 262), 5.25 Gm. Don Baxter Intravenous Products Corporation, Chicago.

Sterile 10% Dextrose Solution in Vacoliter Container.—Each 100 cc. contains dextrose, U. S. P. (New and Nonofficial Remedies, 1932, p. 262), 10.5 Gm. Don Baxter Intravenous Products Corporation, Chicago.

Ampules Scopolamine Stable-Roche, 1/100 gr., 1 cc.—Each ampule contains 1.2 cc. (1 cc. contains 0.0006 Gm. of scopolamine hydrobromide). Hoffman-La Roche, Inc., Nutley, N. J. (*Jour. A. M. A.*, February 25, 1933, p. 574.)

FOODS

The following products have been accepted by the Committee on Foods of the American Medical Association for inclusion in Accepted Foods:

Peerless Hard Wheat Flour (Bleached) (Collin County Mill & Elevator Company, McKinney, Texas).—A "standard patent" hard wheat flour; bleached. It is intended for commercial bread baking.

Pennant Sorghum Flavored Syrup (Union Sales Corporation, Columbus, Ind.).—Corn syrup flavored with sorghum syrup, claimed to be suitable for all cooking, baking and table uses. (*Jour. A. M. A.*, February 4, 1933, p. 339.)

Prune Krush Brand California Pure Prune Pulp (California Fruit Krush Co., San Francisco).—Cooked, pureed prune pulp; in tins. It is claimed to be used for all table uses of prunes, is laxative and may be used in soft diets.

That Good Flour—Heliotrope Patent (Bleached) (Oklahoma City Mill & Elevator Company, Associate of General Mills, Minneapolis).—A patent flour milled from hard winter and soft red winter wheat; bleached.

Pfizer Citric Acid, Anhydrous (Charles Pfizer & Co., Inc., Brooklyn).—Coarse granular, fine granular or powdered anhydrous citric acid meeting all U. S. P. tests for hydrated citric acid for purity; assaying not less than 108.8 per cent as U. S. P. citric acid. It is for use in foods when an organic acidulent is desired.

Prudence Boston Brown Bread (Boston Food Products Company, Boston).—Canned "Boston Brown Bread" containing wheat and rye flours, corn meal, New Orleans molasses, salt, baking soda and caramel (burnt sugar).

Maltex Cereal (Malted Cereals Company, Burlington, Vt.).—A mixture of lightly toasted coarsely ground wheat with the coarse bran removed, granular baked malted wheat flour and a small amount of salt. It is claimed to be a malt flavored cereal for table use.

Jewel Extra Fancy Head Blue Rose Rice (Jewel Tea Co., Inc., Barrington, Ill.).—Whole, hard-brushed rice kernels.

Lucky Bread Graham Flour (Federal Mill, Inc., Lockport, N. Y.).—Whole wheat flour; the bran is moderately fine.

Lucky Whole of the Wheat Flour (Federal Mill, Inc., Lockport, N. Y.).—Whole wheat flour; the bran is moderately fine. (*Jour. A. M. A.*, February 11, 1933, p. 411.)

Morton's Iodized Salt (Morton Salt Company, Chicago).—Table salt containing 0.023 per cent potassium iodide, 0.1 per cent sodium carbonate and 0.7 per cent magnesium carbonate. The iodine in the salt aids in preventing goiter caused by insufficient iodine in the diet.

Atlantic Super-Clarified Gelatin (Atlantic Gelatin Company, Inc., Woburn, Mass.).—Granular and flake plain unsweetened, unflavored gelatins. Food gelatins designed for special uses, prepared from the edible skin and bones of government inspected animals.

Heinz Pure (Virgin) Olive Oil (H. J. Heinz Company, Pittsburgh).—Imported first cold press (virgin) Spanish olive oil. It is claimed to comply with U. S. P. and U. S. Department of Agriculture requirements. (*Jour. A. M. A.*, February 18, 1933, p. 499.)

Marechal Neil Flour (Bleached); Phosphate Added: White Billows Flour (Bleached); Phosphate Added (Collin County Mill & Elevator Company, McKinney, Texas).—"All purpose" patent flours milled from hard and soft wheat and containing 0.5 per cent added calcium acid phosphate. They are claimed to be intended especially for biscuit baking.

Pantry Table Cream (S. M. A. Corporation, Cleveland).—Canned sterile homogenized cream of 18 per cent milk-fat content.

Sweet Pea Self Rising Flour (Bleached) (Collin County Mill & Elevator Company, McKinney, Texas).—A self-rising "stuffed straight" flour containing a blend of flours from hard and soft wheats, calcium acid phosphate, salt and baking soda. It is especially intended for biscuit baking.

Pfizer Glucono-Delta-Lactone (Charles Pfizer & Co., Inc., Brooklyn, N. Y.).—A purified anhydride of gluconic acid. It is claimed to be for use as an acidulent in foods such as bakery and fruit products, and baking powder.

Heinz Strained Spinach (H. J. Heinz Company, Pittsburgh).—Canned comminuted and strained cooked spinach re-

taining in high degree the mineral and vitamin contents of the natural product. (*Jour. A. M. A.*, February 25, 1933, p. 576.)

ACCEPTED DEVICES FOR PHYSICAL THERAPY

The following devices have been accepted by the Council on Physical Therapy of the American Medical Association for inclusion in its list of accepted devices for physical therapy:

AMPLEAIR.—The purpose of the Ampleair Filtering Machine is to filter the air supplied to a small office room or bedroom, and more particularly for ridding the air of pollen as an adjunct for the relief of hay fever symptoms. In case of either extremely cold or extremely hot weather a recirculating damper in the entrance duct can be turned, thus stopping the incoming air and recirculating and filtering the air within the room. It is claimed that the Ampleair will supply sufficient filtered air for a small office or bedroom occupied by two or three people and will serve as an adjunct in the relief of symptoms of hay fever. Independent Air Filter Company, Chicago. (*Jour. A. M. A.*, February 18, 1933, p. 497.)

COLD-QUARTZ ULTRAVIOLET GENERATOR.—The apparatus consists essentially of a Geissler tube (grid) made of fused quartz, a step-up transformer and a regulating choke coil. It is highly evacuated of air and the space is supplanted with an atmosphere of rare gases, xenon, krypton and argon, and a few drops of mercury. The Cold-Quartz Ultraviolet Generator operates on 110-120 volt alternating current. Evidence has not been received from the firm to substantiate the claim that radiations from this lamp will cure or protect against rickets in children. It is reasonable to assume, however, that the cure of rickets in animals with radiations from the Cold-Quartz Ultraviolet Generator might well be interpreted as sufficient evidence, and equal effectiveness may be presumed when the radiations are applied to rachitic babies. A point still under consideration is whether the radiation will at the same time destroy vitamin D as well as activate it. It seems to have a place in the treatment of skin diseases and infections, but this has not been fully established. Conclusive evidence must be presented to substantiate its efficacy as a dental therapeutic agent. Its use by a layman as a sunlamp is considered dangerous. The use of goggles by the operator and the patient is advised. Electro Therapy Products Corporation, Ltd., Los Angeles, Calif. (*Jour. A. M. A.*, February 25, 1933, p. 573.)

PROPAGANDA FOR REFORM

SIRIAN ULTRAVIOLET LAMP NOT ACCEPTABLE.—The Council on Physical Therapy reports that the Sirian Ultraviolet Lamp, sold by the Arcturus Radio Tube Company in Newark, N. J., resembles an ordinary incandescent lamp having a tungsten filament enclosed in a glass bulb that transmits the ultraviolet radiations of wave lengths longer than 2,800 angstroms. The lamp is made in four sizes, 60 watts, 100 watts, 150 and 300 watts. The measurements on the 150-watt lamp reveal a little ultraviolet radiation of wave lengths between 3,130 and 3,340 angstroms not generally considered useful for therapeutic purposes. The ultraviolet radiation intensities available appear to be only from one-fiftieth to one one-hundredth of the requirements of the Council on Physical Therapy. In the small pamphlet called "Sirian Ultraviolet Light, 'A Little Sun in Each Lamp,'" there appear certain objectionable phrases as "healthful tonic," "health-giving energy," and "builds up resistance to disease." The Council on Physical Therapy declared the Sirian Ultraviolet Lamp ineligible for inclusion in its list of acceptable devices because: First, the intensity of ultraviolet energy is too low to meet the minimum specifications of "Ultraviolet Radiation Useful for Therapeutic Purposes—Specification of Minimum Intensity or Radiant Flux: Second Communication" (THE JOURNAL, July 9, 1932, p. 125); and second, the aforementioned health claims recorded in the concern's advertising matter and descriptive literature are unwarranted. (*Jour. A. M. A.*, February 4, 1933, p. 338.)

KIDDIE KANNED SIEVED FOODS—Sieved Vegetables, Fruits and Soups (Sieved Foods for Infants and Invalid Feeding)—Acceptance Withdrawn.—The manufacturer, Kiddie Kanned Foods, Inc., Seattle, has ignored requests for the required information and data for these foods which are now being called for by the committee under its present rules and regulations for all accepted foods. The acceptance of these Kiddie Kanned Foods and the privilege of the use of the committee seal, therefore, are withdrawn. (*Jour. A. M. A.*, February 4, 1933, p. 338.)

SAC-A-RIN BRAND OF CANNED VEGETABLES—Acceptance Withdrawn.—The Committee on Foods reports that the manufacturer, Kings County Packing Company, Ltd., Oakland, Calif., has not provided the required information and data for these foods which are now being called for by the committee under its present rules and regulations for all its accepted foods. Therefore, the acceptance of the Sac-A-Rin Brand of Canned Vegetables and the privilege of the use of the committee seal are withdrawn. (*Jour. A. M. A.*, February 4, 1933, p. 338.)

KRINKO NOT ACCEPTABLE.—The Committee on Foods reports that the Wheat Krinkler Corporation, Columbus, Ohio, submitted a packaged, cleaned and scoured soft red winter wheat called "Krinko, Choice Table Wheat." The advertising was adjudged in gross violation of the committee's policies and principles for good advertising. The company was advised of the committee's recommendations and agreed to revise the advertising. Proof of a revised advertising booklet, "Variety, Economy, Health," was criticized, but many of the recommendations and criticisms were ignored in the printed copy. This Krinkled Wheat, therefore, is not listed among the committee's accepted foods. (*Jour. A. M. A.*, February 4, 1933, p. 338.)

JERUSALEM ARTICHOKES.—The *Pittsburgh Medical Bulletin* calls attention to a newspaper advertisement describing artichokes as "The new and only non-starch vegetable garnish for your Thanksgiving turkey. Highly recommended for diabetic and reducing diets." The claim has been advanced that the artichoke, though containing 17 per cent carbohydrate, contains a sugar, inulin, which is peculiarly suited to the needs of the diabetic patient. The hydrolysis of inulin and its subsequent utilization in the body is no different from that of other sugars, as far as the metabolism of the diabetic patient is concerned. As the *Pittsburgh Medical Bulletin* succinctly remarks, "If the doctor will do the prescribing and the grocer will do the selling, this will be a safer and a better world." (*Jour. A. M. A.*, February 4, 1933, p. 342.)

SERVEX.—No report on "Servex" has been made either by the Council on Pharmacy and Chemistry or by the A. M. A. Chemical Laboratory. In the advertising for this product there appears the following statement in regard to composition: "The formula of this antiseptic includes boric acid, quinine, chinosol, oxyquinoline, zinc phenolsulphonate, scientifically prepared in proper proportions and blended together by our exclusive, scientific process. . . ." This statement is nonquantitative and therefore essentially meaningless. Recently the product was found misbranded by the Food and Drug Administration of the United States Department of Agriculture. Analysis by the government chemists showed the product to consist essentially of boric acid (86 per cent), oxyquinoline sulphate (Chinosol), and quinine sulphate, perfumed. (*Jour. A. M. A.*, February 4, 1933, p. 360.)

SO-CALLED SPECIAL "DIABETIC FOODS" OR SPECIAL FOODS FOR SUGAR AND CARBOHYDRATE RESTRICTED DIETS.—There is authoritative evidence that commercially prepared special "diabetic foods" are of limited usefulness to the diabetic patient and that the availability of insulin makes them no longer necessary. The designation of a food as a "diabetic food" merely because it is low in carbohydrates is now unwarranted and misleading and gives the erroneous impression either that the food taken in unrestricted quantities in diabetes is harmless or that it has remedial action. Lay advertising for these special foods shall not include disease names such as diabetes nor directly or indirectly indicate that the foods are curative or increase the ability of the body to utilize sugar, or give the impression of harmlessness when eaten in unrestricted amounts by diabetic patients. Advertising of a medicinal or therapeutic character shall be limited to medical periodicals or material for physicians exclusively. The package label shall conform to the preceding requirements. (*Jour. A. M. A.*, February 11, 1933, p. 411.)

(Continued on page xvi)

INDIANA UNIVERSITY SCHOOL OF MEDICINE

WILL PRESENT AN INTENSIVE TWO WEEKS'

POSTGRADUATE COURSE

Work will be so arranged that physicians wanting to take work in the specialties may attend in two-day periods; physicians who wish may attend the whole course.

Complete schedule of classes and instructors will be announced in the May issue of this Journal.

Interested physicians may write to Dean W. D. Gatch, Indiana University School of Medicine, Indianapolis, and complete details will be sent at the earliest opportunity.

Every member of the Indiana State Medical Association is invited to attend this postgraduate course.

Minimum registration fee.

Watch for Complete Details in the May Issue

During the thirty-four years of its pharmaceutical experience, the policies of Pitman-Moore Company have been dominated by the ideals expressed in our Laboratory Creed which, prominently displayed throughout every department, meets the eyes of all who have to do with the making of Pitman-Moore products, many times each working day. This Creed reads:

"It is no small thing to know that on what we make, may depend whether life shall be preserved or shall perish."

PITMAN-MOORE COMPANY

INDIANAPOLIS



MEETING THE PROBLEM OF

MALNUTRITION

—especially in children who dislike milk

WHILE malnutrition in children may be due to premature birth, to some constitutional debility or the development of some serious disease, the great majority of cases are due to improper or faulty diet.

Insufficient milk is by far the most serious failing in children's diets. This is due, no doubt, to the fact that so many youngsters dislike milk and refuse to drink it. More and more physicians are meeting this problem by prescribing Cocomalt — which is as alluring as chocolate soda to children.

Prepared as directed, Cocomalt adds 110 extra calories to a cup or glass of milk—increasing the protein content 45%, the carbohydrate content 184%, the mineral content (calcium and phosphorus) 48%. It is rich in Vitamin D, containing no less than 30 Steenbock (300 ADMA) units of Vitamin D per ounce—the amount used to make one cup or glass.

This rich Vitamin D content, combined with the *extra* calcium and phosphorus which Cocomalt provides, aids substantially in the development of strong bones and teeth.

Cocomalt comes in powder form only—at grocers and drug stores—in ½-lb. and 1-lb. cans. Also in 5-lb. cans for hospital use, at a special price. R. B. Davis Co., Hoboken, N. J.

Cocomalt is accepted by the Committee on Foods of the American Medical Association

Free to Physicians

Send your name and address for a trial-size can of Cocomalt, *free*.

Cocomalt

DELICIOUS HOT OR COLD

Cocomalt is a scientific food concentrate of sucrose, skim milk, selected cocoa, barley malt extract, flavoring and added Sunshine Vitamin D.

ADDS 70% MORE FOOD-ENERGY NOURISHMENT TO MILK

(Prepared according to label directions)



R. B. DAVIS CO., Dept 83 Hoboken, N. J.

Please send me a trial-size can of Cocomalt, free.

Dr._____

Address_____

City_____ State_____

(Continued from page 208)

DEWAN'S DEPILATORY.—For some time past there has been an aggressive advertising campaign for a product called "DeWan's Permanent Hair Remover." DeWan's Laboratories, Inc., was incorporated under Illinois laws in the spring of 1932, but apparently did not become active until September, 1932. Earlier, the company exploiting the DeWan preparation was the Saint Aubin Corporation at 43 East Ohio Street, Chicago. Later this became the DeWan Laboratories, Inc., at the same address. Still later this became the DeWan Laboratories at 11 East Austin Avenue, Chicago, while the latest name is DeWan-Hollywood Laboratories, Inc., Hollywood, Calif. The DeWan depilatory has been heavily advertised under the names of various department stores. These large and expensive advertisements are said to have been paid for by the DeWan concern itself. Analysis shows that the DeWan preparation is just one more of the innumerable alkaline sulphides with which the depilatory field is flooded. Alkaline sulphides have the power of dissolving hornlike substances such as hair, and obviously anything that is powerful enough to remove the hair may easily be powerful enough to remove the skin. The A. M. A. Chemical Laboratory was asked to examine the DeWan preparation. Qualitative tests indicated the presence of sulphides, sulphate, chlorides (trace), starch, zinc, strontium, calcium and sodium (trace). Barium, magnesium, potassium and thallium were not found. The report of a petrographic examination indicated the presence of zinc oxide, strontium sulphide, and a relatively large amount of orris root (starch). The newspaper advertisements and the advertising that accompanies the trade package speak of "rare oils and secret ingredients which do not kill the root but sterilize it so it cannot reproduce." It is a sorry commentary on the public's intelligence that this sort of buncombe can appear in the public prints and that supposedly reputable newspapers and department stores will, for the money there is in it, give publicity to such nonsense. (*Jour. A. M. A.*, February 18, 1933, p. 515.)

CRYSTALLINE VITAMIN D.—It has been apparent for some time that the irradiation products of ergosterol represent a mixture of substances of which only a varying proportion is the active vitamin D. Consequently the question has arisen whether the toxicity known to be exhibited by very large doses of irradiated ergosterol are due to the vitamin itself, so that one could speak properly of hypervitaminosis, or to contaminating derivatives produced by the transformations of the natural sterol. Considerable progress has been made more recently by the fractional purification of the products of ergosterol irradiation resulting in the isolation of crystalline substances of noteworthy potency out of the mixtures formerly obtained. The latest report, by Professor Windaus, records the isolation of what appears to be the antirachitic vitamin D in pure crystalline form. At least five other concomitant products of the irradiation process have also been separated—most of them in crystalline form. None of these exhibit antirachitic potency. Windaus and Luttringhaus have come to the conclusion that the pure vitamin D is not entirely devoid of toxicity. A dose of 0.075 mg., representing 3,000 international D units, is toxic to mice. The relative toxicity of pure vitamin D has been demonstrated to be far less than that of its common contaminants. Whether the naturally occurring vitamin D of cod liver oil is actually identical with the chemically produced compound remains to be ascertained. (*Jour. A. M. A.*, February 11, 1933, p. 426.)

FIG AND BRAN NOT ACCEPTABLE.—The Committee on Foods reports that the Battle Creek Food Company, Battle Creek, Mich., submitted a product called "Fig and Bran," prepared from wheat bran, California figs, malt extract, sucrose, wheat germ, salt and an extract of brewers' yeast and vegetables. The name, by giving first place to "figs," emphasizes the fig content over that of the bran, thereby connoting that the figs are in greater proportion than is the bran, which is contrary to fact. The name therefore is misinformative and misleading. The company was advised of the committee's opinion but declines to make the recommended change in the name. This product therefore is not listed among the committee's accepted foods. (*Jour. A. M. A.*, February 25, 1933, p. 576.)

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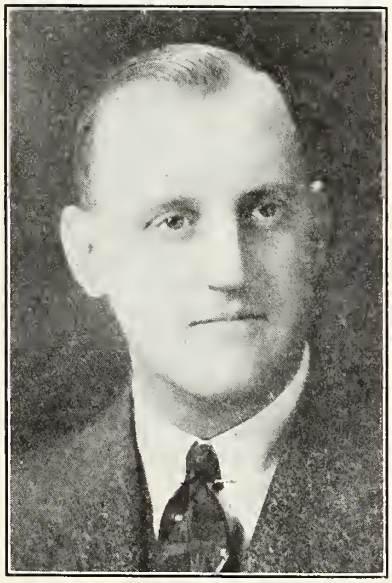
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ORIGINAL ARTICLES

REORGANIZATION OF THE INDIANA STATE BOARD OF HEALTH*

Doubtless all of our readers are familiar with the attempt of Governor Paul V. McNutt to bring about such reorganization of government as will make it possible to save a considerable amount of the taxpayers' money, and at the same time afford as good, or even better, service than has heretofore been available. The reorganization of the State Board of Health is a part of the Governor's plan, and is naturally of considerable interest to the medical profession.

There is no need to disguise the fact that there has been, in times recently passed, considerable



JOHN H. HARE, M. D.
Secretary of the Indiana State Board of Health

cause for criticism of the broadening activities of this branch of government. Attention has been particularly directed toward the work of the Division of Infant and Child Hygiene, the Hygienic Laboratory, and the subsidization of the Venereal Clinics in different cities of the state. Not only have these branches cost a considerable sum of money, but they have also entered into forms of



WILLIAM F. KING, M. D.

Dr. King, a member of the Board since 1910 and secretary from 1922 to 1933, will act as general chairman of the committee in charge of the Indianapolis meeting of the American Public Health Association, of which he is a member of the board of governors. The meeting will be held in October.

medical practice which have essentially put the state in competition with the practitioners of medicine. The manner in which the work of these departments is to be carried out is described later in this article.

The present set-up is designed to correct these abuses, improve the quality of the proper services of the State Board of Health, and to effect a saving of probably $75,000 a year.

The new organization is delighted to be able to report that the services of Dr. John H. Hare, of Evansville, Indiana, have been secured as secretary. Dr. Hare has been for several years the Councilor for the First District of the Indiana State Medical Association, and is, of course, thoroughly familiar with the ideals of organized medicine. Furthermore, he was a member of the old

* Prepared and published under the authority of the Executive Committee of the Indiana State Medical Association.

State Board of Health, and for this reason is acquainted with the work and the personnel. Until the last few days he has been a practitioner of medicine, and is therefore fully qualified for that angle of the work. Dr. Hare has an excellent personality and appears to be a man ideal for the place. His appointment was made by the Governor after consultation with physicians high in the councils of the Indiana State Medical Association.



THURMAN B. RICE, M. D.
Assistant Secretary of the Indiana State Board of Health

His assistant will be Dr. Thurman B. Rice, Professor of Bacteriology and Public Health of the Indiana University School of Medicine. Dr. Rice, of course, will continue his connection with the University, giving but a part of his time to the Board of Health. His suitability for the place is attested by the fact that he teaches these subjects in the School of Medicine, has been director of the hygienic laboratory of the State Board of Health for over two years (1924-1926), and has been continuously in touch with the organization since 1926. As director of the laboratory, Dr. Clyde G. Culbertson has been chosen. Dr. Culbertson has been doing exactly similar work at the University hospital laboratories for the past two years and has made an outstanding success of the work there. He, likewise, will continue his connections with the University. The organization is in the position to know that Dr. Culbertson's work is of exceptionally high quality.

Rabies Treatment

The work of the Pasteur laboratory will be under the direction of Dr. Culbertson, Director of the Laboratory of Hygiene, but the actual giving of the Pasteur treatment will be done in the admitting room of the Long Hospital. By this means these patients will be in such a place as can properly take care of them in case their dog-bite wounds should need attention, and also in case they should get reaction from the treatment. These patients who come from a distance are required to be housed and fed by the state. In the vicinity of the Medical School campus there are many private homes where the owners would be glad to rent rooms to these patients at a very low cost. The patients will be fed in the "help" dining room of the hospital, at a very low figure—probably as low as 10 cents a meal, though the food will be of the highest quality. By this means it will be possible to save about a dollar a day on each patient, which will amount to approximately fourteen dollars on each case. Likewise, the patients will be much more comfortably and properly housed than when they were given rooms in downtown hotels and fed in restaurants. The attention of the profession is called to the fact that there is a provision whereby patients can be treated in their home communities by their own doctors, in the same way that they can be given free anti-toxin by their home physician. The new organization emphatically urges that all communities be responsible for the treatments of persons bitten by dogs.



CLYDE G. CULBERTSON, M. D.
Director of the Laboratory

Maternal and Child Welfare

The work of the Division of Infant and Child Hygiene is to be discontinued, except in its strictly educational phase. The new organization is extremely anxious that the interest of the public in these matters should be encouraged and as need arises for educational programs, the medical profession and the University School of Medicine will stand ready to supply talent for such work. The

communities under the leadership of the county medical societies are urged, however, to take the initiative in all of this work. Neither the State Board of Health nor the State University wishes to force anything of this sort upon a given community, but is glad to co-operate through the medical society in every way possible with clubs, parent-teacher associations, and other groups qualified to carry on such work. In all such activities the local medical association will be consulted before action is taken.

association have been appointed by Dr. Weinstein, president of the Indiana State Medical Association, and are Dr. A. M. Mitchell of Terre Haute; Dr. Harry Langdon of Indianapolis; and Dr. B. W. Rhamy of Fort Wayne. Those representing the Board of Health and the University are Dr. John H. Hare (who is a Councilor of the State Medical Association), Dr. A. F. Weyerbacher (who is treasurer of the State Medical Association), and Dr. Thurman B. Rice (who is a member of the editorial board of the State Association JOURNAL).

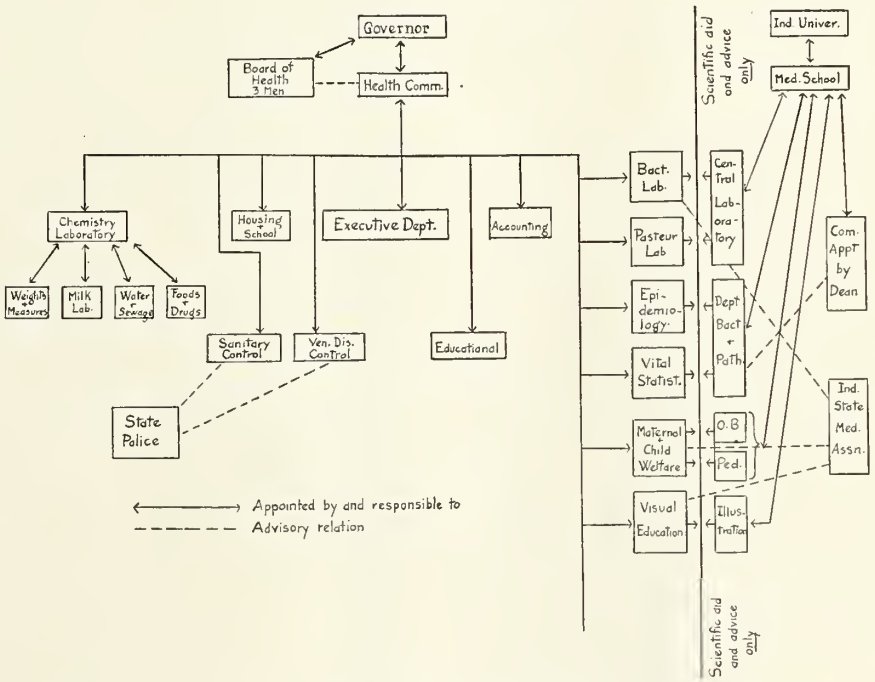


Diagram of the Present Working System of the Indiana State Board of Health, Showing the Organization of the Indiana State Board of Health in its Relation to the State University and the State Medical Association.

LABORATORY WORK COMMITTEE

As an evidence of the attitude which the new organization is to take toward its responsibilities, they want particularly to cite the plans which are being made for the conduct of the hygienic laboratory. All blood chemistry, for example, is to be discontinued, as is also all work on urine which is not directly attributable to the transmission of communicable diseases as these procedures are not preventive public health measures. A strenuous effort will be made to discourage the use of the laboratory except for the two purposes for which it was originally designed, namely, the control of transmissible disease, and the provision of a service for the indigent sick. In order that the interests of the medical profession shall be observed, a dual committee has been appointed. Three men will represent the Board of Health and the University, and three other men will represent the State Medical Association. It will be the purpose of this committee to arrange working rules for the laboratories. The men who represent the medical

We hope that the personnel of this committee will convince any skeptical person of the desire of the new organization to lean backward in its observance of the ideals of good medical practices and ethics. It is also the hope of the organization that the character of these men will be a sufficient guarantee to the laymen of the state that the interests of the public will be considered.

State support for venereal clinics is to be withdrawn. There is no doubt whatever that the venereal diseases are extremely important public health problems. It is the desire of the new organization, however, to place the responsibility for those problems exactly where it belongs; that is, in the home community. If a particular town or county wishes to establish such clinics, the organization will be only too glad to be of assistance.

CO-ORDINATED EFFORTS

For several years the State Board of Health, the State University School of Medicine, and the State Medical Association have been more or less

at cross purposes. Such a condition is most improper and to be lamented. As short a time ago as the last state meeting, the situation seemed to be one that was far from solution, though resolutions pointing out the desirability of making some change were passed. The reorganization under Governor McNutt offers a marvelous opportunity to correct the difficulties. As a matter of fact, the Governor has consulted physicians in considerable number, and is very anxious to do what is right in this connection. We bespeak the co-operation of organized medicine for this plan. If there are criticisms, it is hoped that they will be as sincere as have been the efforts of those who are responsible for this reorganization. Obviously it is impossible for everybody in such a re-arrangement to get everything that he might desire. It certainly seems, however, that the organized physicians of the state have gotten pretty nearly everything that they can reasonably ask. This arrangement has the approval of the president, president-elect, and of some three or four past presidents of the association. It also has been approved by the executive committee and by at least three councilors who have taken part in the deliberation.

The role of the Indiana University School of Medicine must not be misunderstood in the present relation. The University was asked by the Governor to assume certain responsibilities. At first those in charge were quite reluctant to do this because they were afraid that the motive would be misunderstood. As it now stands, the University is taking no part whatever, except that it will lend the services of its scientific staff to the Board of Health for scientific and educational purposes only. The University will have nothing to do with the enforcement of laws or the various police functions of the Board of Health. All laboratories and offices will remain in the old location and the relation of the University will be such that at any time it will be a very easy matter for the University to drop out of the picture. The only purpose of that institution is to give aid at a time when aid is greatly needed. Under no circumstances will the University become aggressive, or attempt to exercise influence or political pressure. Likewise, it will not attempt to determine the policies of the Board of Health or the medical profession.

The new organization believes that this is the biggest step that has ever been taken in Indiana away from state medicine.

ROENTGENOLOGY FROM A SURGICAL STANDPOINT*

RALPH L. LOCHRY, M. D.
INDIANAPOLIS

It is always well to stress the importance of x-ray findings in doubtful abdominal conditions in children where an obscure pneumonia may present the picture of a surgical abdomen; or in an acute epigastric pain in adults, found to be due to a spontaneous pneumothorax, that many times is not discovered until an x-ray examination is made. While such conditions are not very frequent, they do arise.

In the confusing picture of the child that is below normal, and an x-ray of the chest has been requested, it has been my practice for years to take films of the nasal accessory sinuses, whether requested or not, and have been surprised to find a very large percentage showing sinus infection which was responsible for the physical condition, and was not even suspected.

One need only mention the need for careful x-ray examination of patients presenting the confusing picture of either acute stomach or cardiac conditions, or the equally needful x-ray of the chest in malignancy of the testicle or breast, or sarcoma of an extremity. Little need is there to amputate an extremity with rather advanced metastasis to the lungs.

There is no need to dwell upon the valuable help in thorough x-ray of the gastro-intestinal tract. The confirmation of stomach and duodenal ulcers is a daily practice, but occasionally the unusual is found, such as diaphragmatic hernia, and all kinds of malposition of the colon, etc. In lantern slides to be presented I will show such abnormalities—which would be valuable information to have in any case, such as a mid-line caecum and appendix. Even if the patient were well at the time of examination such knowledge would be of great value should the patient develop mid-line pain at some future time. All roentgenologists will agree that it would be well for everyone to have a gastro-intestinal examination, even when in the best of health, to establish the knowledge of the location of abdominal viscera.

Surgeons are agreed that there is great value in the x-ray findings in gall bladder disease with sodium dye. When the gall bladder fails to visualize following administration of dye—that is, after at least two attempts—there is definite gall bladder disease, even though the macroscopic appearance is not bad.

I would like to advise surgeons who would like to know the source of any sinus tract, such as a fecal fistula, a suspected psoas abscess, etc., that injection of the tract with thin, opaque media such as sodium iodide 15 per cent, or lipiodol, preceding x-ray examination, will give the most information. Barium meals or enemas are usually not of great value.

At this time I would like to stress the great importance of careful and thorough x-ray examination of any painful area that persists, whether a known malignancy exists or not. Many times bony metastasis has been found when a known primary lesion was not evident. Always investigate any painful area anywhere in the body, when a known malignancy does exist.

* Presented before the annual session of the Indiana State Medical Association at Michigan City, September, 1932.

I would also stress the careful and thorough x-ray examination of any painful area along the spine or pelvis following any fall or, especially, an automobile accident. Compression fractures of vertebral bodies and fractures of the pelvis are not uncommon findings.

The aid in locating foreign bodies in the trachea, esophagus, stomach or intestinal tract, need only be mentioned.

Last, but not least, I would like to emphasize the great value of x-ray in connection with diseases common to the urinary system. The assistance in diagnosing urinary calculi, deformities of the kidney pelvis or calices, and ureter, by retrograde pyelography, also the bladder deformities as demonstrated by cystograms, have long been known, but the helpful assistance of intravenous pyelography is a rather new development that is invaluable in the patient who is too sick to undergo a cystoscopic examination.

In conclusion, I wish to stress this point—do not always use the x-ray department as a final and certain terminal diagnostic means. Certainly we can tell about fractures of most bones; usually about urinary calculi or metallic foreign bodies; the existence of gastric or duodenal ulcers; active pulmonary tuberculosis; but many conditions are not positively and certainly diagnosed by x-ray, and the information obtained plus the clinical picture is confirmation of the existing pathology. Use the x-ray department as another aid in diagnosis and the x-ray specialist as a consultant rather than as a photographer to show certain easily shown positive facts.

DISCUSSION

KEITH T. MEYER, M. D. (Evansville): In addition to those phases of radiographic diagnosis which Dr. Lochry has already discussed, I wish to emphasize the value of the roentgenogram as an important aid in the diagnosis of acute obstructions in the small intestine. The radiographic diagnosis is based on the fact that in the normal adult, very little, if any, gas is visualized on the roentgenogram. In obstruction of the small intestine we know that the intestine will dilate and fill with gas and fluid above the site of obstruction. The radiograph will reveal either one or the other of two characteristic types of dilated loops of small intestine.

1. The herring type.
2. The sausage-shaped type.

Either type is significant of small intestine obstruction. When the patient is taken in the erect position a distinct fluid level can be visualized in the dilated loops of small intestine, in a good many instances.

Concerning the radiographic technique it is not necessary to give the patient a barium meal: (a) because the patient will not be able to retain the meal; (b) the gas in the small intestine makes an excellent contrast media and the barium will not be necessary. If the patient is in too serious a condition to move to the radiographic department, the radiograph can be taken in the patient's room, by means of the portable x-ray machine.

I wish to emphasize the value of an early diagnosis in acute obstructions of the small intestine. Dr. John M. T. Finney, Sr., in over two hundred cases, reports a mortality rate of 38 per cent. However, in those cases in which a diagnosis had been made in the first four or five hours, the mortality rate was reduced to 5 per cent. The roentgen ray, therefore, should be used as an aid in the early diagnosis of acute obstructions of the small intestine.

ATELECTASIS*

W. G. CRAWFORD, M. D.
TERRE HAUTE

The subject of atelectasis, or massive collapse, has aroused much interest in recent years, if the great volume of literature contributed can be taken as a criterion. The majority of the work has dealt mainly with the postoperative massive type, of which a brief review is given, but localized and massive collapse exist, other than postoperative, and of these I wish later to present three case reports.

The historical facts, together with many of the early experimental studies on this subject, are now well known and need no repetition except to pay tribute to such pioneers as Lichtheim, Gairdner, Pasteur, and others who made their observations so accurately without the aid of x-ray or modern laboratory procedures.

Since 1925, the subject of atelectasis has brought contributions from many well known investigators and clinicians, the result of which has been a better understanding and a more rational method of treatment of a disease that had virtually been obscure.

Packard has made the following classification of the massive type of this disease:

Group I. Those cases described by Pasteur complicating diphtheritic paralysis of the diaphragm.

Group II. Following operations or gunshot wounds of the chest.

Group III. Produced by obstruction of a bronchus by aspirated foreign body or by tumor.

Group IV. Complicating chronic pulmonary disease, particularly tuberculosis.

Pasteur was of the opinion that paralysis of the diaphragm and accessory respiratory muscles caused the collapse of the wall of the thorax. But paralysis of these muscles and the diaphragm, produced experimentally upon cats, has failed to bring about the condition. This work, done by Elliott and Dingley, led them to the opinion that the collapse was due to bronchial obstruction together

* Presented at the annual session of the Indiana State Medical Association, Michigan City, September, 1932.

with immobilization of the diaphragm, the retained alveolar air being absorbed by the circulating blood.

Lichtheim, in 1876, produced a massive collapse in animals by ligating a main bronchus. That the absorption of the retained air was due to the circulating blood was proved by ligating the corresponding pulmonary vessels of an obstructed area of lung tissue. When this was done it was found that no collapse took place, while if the circulation was not disturbed atelectasis resulted in a few hours.

Since Lichtheim's work, the same experiments have been carried out by Coryllos, Jackson, and others, with identically the same results.

As further proof of the obstruction theory Jackson, Clerf, and other bronchoscopists have been able to relieve massive atelectasis immediately by the removal of a mucous plug or foreign body. Jackson finds mucus plugging a bronchus so dry and hard as to act as a foreign body or it may be so thick and tenacious as to occlude the larger bronchi.

Lincoln Brown thinks there is a decreased aeration ability or diminished respiratory force in connection with bronchial obstruction to bring about the collapse. He has shown, by experimental and clinical observation, that the bronchial secretions not only play an important part in postoperative massive collapse but that the consistency of the sputum determines the type of atelectasis present, the thicker tenacious fluid blocking the larger tubes, producing a wider area of collapse, while the thinner secretions cause a scattered lobular atelectasis.

Johnson gives as his opinion that the secretions need not be exceptionally viscid or tenacious to obstruct a bronchus if the respiratory movements are too weak to expel them, this weakness being due to "pain following abdominal operations, unfavorable posture, tight dressings, the abolition of the cough reflex by morphine, or mechanical interference with the diaphragm."

Faulkner and Faulkner believe that the condition can be explained on a mechanical and infectious basis. They think it is due to the influence of "internal drainage" upon an excessive amount of intrabronchial secretion. Internal drainage is defined as the spilling of material from place to place within the tracheo-bronchial tree, spreading infection and interfering with the aeration of the lung. The sites at which the secretions collect and produce the collapse depend upon "the amount, virulence, and viscosity of the secretions, the relative positions of the various bronchial openings, the course of the bronchial stems, the posture of the patient, and the length of time that the patient remains in a given position."

The role that these retained secretions and atelectasis play in the causation of postoperative pneumonia, has been treated exhaustively and convincingly in a series of articles by Henderson, Haggard, Coryllos, and Birnbaum. The result of this work has been the almost general employment of carbon dioxide and oxygen inhalations following surgical operations or carbon monoxide asphyxia, for the prevention of postoperative and postasphyxial pneumonia, and also as an early treatment after any pneumonia has developed. They have proved that it causes a hyperventilation of the lung by deep breathing, thereby furnishing air to the alveoli which helps in the expulsion of the bronchial secretion.

Collapse from tumor or aspirated foreign body may be massive or localized, depending upon the location of the obstruction. Massive atelectasis of a lobe follows main bronchus occlusion, while only localized collapse follows a smaller branch obstruction. This is not always true according to Van Allen and Linskog, who claim that the branches of a single lobe intercommunicate and unless the main bronchus of a lobe is obstructed there will be collateral respiration at the periphery of the lobe which prevents a collapse of the area distal to the obstructed bronchus. They state, however, that the minute openings or communications may become obstructed with secretions or from a "shut down" due to shallow breathing and thus cause an atelectasis.

Massive or partial collapse from chronic pulmonary tuberculosis has been reported by Packard, Hennell, Korol, and others. Korol believes as Husten that the terminal non-ciliated bronchioles are favorite places for the tubercle bacilli to lodge with a resultant tubercle formation. The distal air cells collapse and induration takes place. Larger bronchi may be occluded in the same way with larger areas of collapse and scar tissue formation.

Large tuberculous lymph nodes may cause pressure on the trachea or large bronchi, causing a collapse of a whole lobe or lung. If this is permanent "a certain degree of re-expansion remains possible for a long time, but eventually the alveolar walls adhere together obliterating the air spaces and finally the whole region is converted into a pigmented fibrous mass, producing a gross picture of 'collapse induration.'" Packard asserts that a rapid massive fibrosis of a lobe or whole lung is probably in its origin a massive atelectasis, and according to Hennell "It is a conservative process and may be responsible for the mild clinical course as well as the slow progress of the pathological process after it is established."

Long continued pressure from fluids or gases in the pleural sac will produce this same condition.

The symptoms of postoperative massive collapse come quickly and their gravity is at once apparent. In one to two days following operation there is a sudden attack of dyspnoea, rapid pulse, respirations, and cyanosis. There is generally a rise of temperature, without a preceding chill. Pain may or may not be present.

The physical signs are immobility or retraction

of the affected side, marked displacement of the heart and trachea toward the involved area, and dullness present over the collapsed lung. Breath sounds are faint at first, bronchial breathing may follow with increased whispered voice and absence of tactile fremitus. If rales are present they may be coarse or musical, but they are more likely to be present as the lung begins to re-expand.

A very confusing set of symptoms may be connected with this condition which can only be cleared with the aid of the x-ray. It shows a dense and uniform shadow with the heart and mediastinum displaced toward the affected side. The diaphragm is elevated and immobile if seen through the fluoroscope. The ribs are slanting and close together.

There are a few measures that will sometimes give immediate and lasting results in the treatment of this complication. It has already been mentioned that carbon dioxide in oxygen has been used in the clearing up of atelectasis which is considered by some as the first step in pneumonia. And also the striking results obtained by the use of the bronchoscope in removing mucous plugs and aspirating thinner fluids has been reported. Sante has produced results by rolling the patient on the unaffected side and urging a cough at the same time.

Artificial pneumothorax has been used by Glenn, Packard, and Habliston. It brings immediate relief of the intense discomfort by returning the heart and mediastinum to normal position.

It is reasonably easy to diagnose a massive collapse with the history, physical signs, and the aid of the x-ray, but the cases of partial or localized atelectasis, with very few of the typical signs, will present a more difficult problem. The close co-operation of a medical team is sometimes necessary to determine the true condition present. This is especially true if the symptoms have developed slowly and the area involved is comparatively small. The following case of tumor of the bronchus is an example of this kind.

Male, age 47; occupation, railway mail service.

February 18, 1932. Came in for the relief of cough and dyspnoea. Family physician also wished a basal metabolic test on account of his fast pulse.

Family History. Unimportant.

Past History. Has never had any sickness except tonsillitis. Tonsils and teeth were removed in the past year.

Present Illness. He developed a cold in his chest the latter part of August, 1931. There was a general aching over body and temperature ranged from 103 to 104. His local physician told him the trouble was in the left lung. The cold seemed to clear up in about ten days but the fever continued. It was decided, after a few weeks, that the tonsils were causing the continued fever and ill feeling. They were removed September 28, 1931. Following this the temperature subsided for ten days, then recurred. Since that time he has seemed to catch cold every few days, cough would get better and worse with each new cold. At the present time he has fever every day, raises a thin white mucus, and has night sweats. He has lost about fifteen pounds in weight. There has never been any pain in his chest, but he is short of breath on exertion.

Physical Examination. Temperature 99 2/5, pulse 112, respirations 28. Blood pressure: systolic 130, diastolic 76. Patient appeared ill, color was sallow and skin moist. Physical examination was negative except the findings in the chest. The heart's apex beat was in the fifth space at the nipple line with a systolic murmur heard best at apex. The chest was narrow but appeared symmetrical. Breath sounds were normal over the left lung but absent on the right from the fifth rib in the axillary line to the base. There was flatness on percussion over the same area. There were no rales in any part of the chest.

The urine showed specific gravity 1.032 and a trace of sugar. Blood count showed red blood cells 2,600,000, white blood cells 16,200, with hemoglobin 72 per cent. Wassermann, Kahn, and Kline tests were negative. Blood culture was negative. Blood sugar 100 milligrams per 100 cc. Basal metabolic rate was plus 28 per cent.

X-ray of chest showed diaphragm obscured on right with a haziness extending up to the fifth rib. The heart was retracted slightly to the right and trachea was also drawn to the right at its bifurcation.

Paracentesis was done and 500 cc. of serous fluid was withdrawn. Pathologist reported a smear from this to show cells with large nuclei which were suspicious of malignancy. A lateral film showed a fluid level in the posterior sulcus of the right side and an atelectatic area of density with apex upward, extending from the hilum downward and posteriorly.

After instillation of lipiodol the posterior branch of the bronchus leading to the right lower lobe was found occluded.

Bronchoscopy, done by Dr. Gillum on February 29th, revealed a growth obstructing the left branch of the right lower bronchus, a portion of which showed, on section, carcinoma, grade III.

X-ray therapy was instituted and on March 26th and June 3rd five radon seeds in all were introduced into the obstructing growth. A few weeks after the radon seeds were used, the character of the sputum changed to yellow mucus containing pus cells and streptococci. His night sweats and fever gradually disappeared.

Bronchoscopic examination on July 8th revealed the mass much smaller in size. X-ray on July 29th demonstrates considerable clearing of the whole field. The density is much less and there is a marked decrease in the size of the atelectatic area. Blood report at this time shows hemoglobin 98 per cent, red blood cells 4,400,000, and white blood cells 8,300. At present he has no discom-

fort, sleeps well, has a good appetite, and has gained thirteen pounds in weight.

Case II is shown to illustrate the complete fibrosis of the left lung following an obstructed main bronchus which took place several years previously.

This case is interesting also from the standpoint of his present health in view of the widespread tuberculous infection through his whole body. The history of these complications, to review them rapidly, is as follows: E. G., age 20, in the early part of 1918 noticed swelling of the left great toe. This was followed shortly by a swelling in the heel of the same foot. The toe was poulticed until it began to discharge. The condition continued in about this stage until the latter part of December, 1918, when first seen by me. On January 1, 1919, the toe was amputated and a circumscribed abscess in the os calcis was curetted. Before he left the hospital an abscess developed on the dorsum of the left foot which was incised. The third metatarsal was found necrosed and was removed. During the summer of 1919 the right ankle began to swell and eventually suppurated. An incision was made and extensive destruction of the lower end of the tibia was found. It became necessary to amputate in February, 1920, after other means had failed to check the process. The left knee began to swell and grow painful during the late summer of 1920. Suppuration finally took place and the leg was amputated above the joint in December of that year. The joint was found to be filled with pus with extensive necrosis of the femur. He has had several cold abscesses and suppurating lymph nodes since that time which were healed with injections of iodoform and ether in oil. In 1925 the right testicle became involved and was removed. The same year a marked kyphoscoliosis appeared from an involvement of the last dorsal and first three lumbar vertebrae. Several months later, without warning of previous lung complications, I found marked dullness and loud bronchial breathing over the whole upper lobe of the left lung. Apex beat was palpated in the mid-axillary line.

A film, taken after the introduction of lipiodol into the trachea in May, 1926, showed the left bronchus completely obstructed and generalized cloudiness over the whole left lung.

In October, 1928, the left epididymis became involved and was removed, leaving the testicle.

A film taken August 13th of this year shows an opacity of the entire left lung. The right lung is clear. He has taken heliotherapy practically ever since his trouble started and is never without a coat of tan. Since his last operation he has had no further complications. There has been no fever or cough, his appetite is good, and he is optimistic enough to take up the study of law.

Case III. Mrs. R. H., age 26, represents a case of atelectasis following the discontinuance, after two years, of artificial pneumothorax. The failure of the lower lobe to expand, with the resultant negative pressure, is probably responsible for the re-opening of the large cavity seen in the upper left lobe.

She was found to have bilateral pulmonary tuberculosis in 1929, and left shortly after for Albuquerque, New Mexico. While living there she was given pneumothorax in the left pleural cavity. This was continued on her return with the result that a gradual disappearance of her symptoms was noted together with the apparent healing of the lesion in the contra-lateral lung. Pneumothorax was discontinued in December, 1931. About two months after discontinuance of pneumothorax the patient returned complaining of uneasiness in the precordial region, accompanied at times by palpitation and dyspnoea. An examination revealed several of the typical signs of atelectasis while the x-ray films showed the heart and trachea retracted to the left. The lower portion of the lung was very dense while the border of the lung was still some distance from the chest wall at the second rib. As there were no symptoms of activity present, it was decided to wait for a while, which was as bad as the first mistake in discontinuing the pneumothorax. When she was next examined her cough, expectoration, and fever had returned. A film was taken which showed an opacity of the whole lower portion of the left lung and a lesser density from the third rib to the apex. There was also a cavity, 2 centimeters in diameter, at the level of the second interspace. The right lung field had infiltrations in the extreme apex and in the first interspace. Pneumothorax was attempted at this time without results.

The patient is now on bed rest in the hope of an arrest of the new lesions, after which the cavity can be compressed by surgical means.

Summary

The cause of postoperative massive collapse has been cleared to a great extent by experimental work and the use of the bronchoscope. Through its investigation a decided advancement in the treatment, and also in the prevention of the condition, has resulted.

Later contributions have shown the existence of atelectasis both localized and massive, other than postoperative.

The plugging of a small bronchus may produce very few of the classical symptoms due to the small area involved.

Many cases of advanced pulmonary tuberculosis with unilateral massive fibrosis are possibly the result of a massive atelectasis. The mild clinical course frequently observed in this type, notwithstanding the extensive involvement, makes it appear as another of nature's ways of attacking this disease.

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DISCUSSION

ROSCOE SENSENICH, M. D. (South Bend): I have in mind some cases typical of the various ways in which atelectasis can occur. I recall that the first one I saw was a case which followed a herniotomy. The onset was abrupt and very spectacular and would, perhaps, with a less careful study of the chest, have passed as one of those types of acute pneumonia which we so frequently used to see following anesthesia, especially ether anesthesia. But examination of the chest would immediately dispel that idea and show us that herein we had an atelectasis.

We had a collapsed lung and not one due to external pressure but due to the rapid absorption of alveolar air following obstruction of a bronchus. This case cleared very quickly following bronchoscopic treatment and a removal of tenacious mucus from the bronchial tube.

The second case was one in which the onset was in the course of a pneumonia. That is rather a peculiar thing, and yet it may occur and quite possibly occurs more frequently than we think.

In this instance the very striking thing was that we had two periods of collapse, or two areas of collapse. We had an area of collapse that developed in the course of the pneumonia which was apparently due to obstruction, was a limited area, gave very typical signs, and by x-ray was confirmed, which relieved itself slowly. Unfortunately, in the course of a prolonged pneumonia with an extension to another area, we again had the same thing occur.

The third case was that in the course of a tuberculosis—a tuberculosis high in the chest. In this instance the collapse was high in the lung rather than the more common thing of having the collapse occur lower in the lung if it is a limited area of involvement. However, it may occur anywhere.

Another case was a very unexpected one—the spontaneous development of atelectasis, in an automobile mechanic who was lying under an automobile, and its exact origin was never definitely known. Its course was very short. The man had a bronchitis and quite probably that was the solution. He had had a bronchitis for a long time, and it is possible that lying in the posture that he was, and straining, perhaps in coughing he aspirated some mucus into the bronchial tube. The case was typical so far as its findings were concerned and the patient made a very rapid recovery without any treatment.

I have been impressed by the signs in chronic asthma at times. All of us have seen asthma in which we have limited areas from time to time exhibiting all characteristics of miniature pneumonia and we feel that probably the infection coincident with the asthma of a chronic type has led to consolidation in a small area of the lung, and no doubt it is true. But I have been impressed also with the fact that at times we have areas develop which exhibit all the characteristics, both on clinical examination and on x-ray, of small areas from which the alveolar air has disappeared and we have a partial collapse. Those areas may be small and they may prevent complete collapse of the lung, owing to associated fibrotic changes in the chest and the fact also that thickened bronchial tubes and other pulmonary structure prevents the limited area from exhibiting all the characteristics accompanying the deflation. However, it is quite possible that that occurs, and one can see how the background develops, for the appearance of such a sequence in that the tenacious mucus and constricted and thickened tubes could very readily, and no doubt do, produce this obstruction sufficient to produce an atelectasis.

Bronchoscopic treatment sometimes requires a little courage, especially if the patient is very ill, and I doubt the advisability if there is a great amount of secretion. For instance, the one spontaneous case I recall had a perfectly enormous amount of thin sputum very soon after the appearance of the atelectasis and one would feel that there might be a pulmonary edema if unaware of the exact condition.

The treatment as outlined, beyond that of bronchoscopic treatment, is more or less palliative. The effort to cough, having the individual lie on the affected side, the use of carbon dioxide and oxygen mixtures—all of those things have some benefit, but most often, unless the condition is too prolonged, a complete recovery takes place.

One of these cases, a pneumonia case, partially

as a result of his pneumonia and greatly depressed condition, ran a long course, with fever, and there was some question later on as to whether the lung was ever going to be fully restored. However, as the months went on, repeated x-ray studies did show that the lung finally returned to at least something near its normal volume and normal function.

The thing which is most to be drawn from a review of these cases, I believe, is the fact that they may occur any time. Like the dilated stomachs and acutely serious intervals that occur postoperatively in many conditions, we may have this also: It may be acute, immediately following an operation, or it may be two or three more days later.

HERNIAL GANGRENOUS APPENDICITIS

S. D. MALOUF, M. D.
PERU

The literature contains numerous reports of the presence of the appendix in hernial sac with the hernial contents, without inflammation, usually an incidental discovery in the course of an operation for the radical cure of the hernia. It is a rare phenomenon to find a gangrenous appendix in a hernial sac. A ruptured, gangrenous appendix and the hernial sac containing only the perforated appendix and a large amount of purulent fluid occurring in the extreme decade of life (88 years in the present case report) is exceedingly rare.

A search of the literature reveals this condition to occur in the majority of cases in right-sided, indirect, inguinal hernias, and occasionally a left-sided hernia containing the appendix was reported.

In 1731 De Garengeot was the first to describe the appendix in a hernial sac. Later cases were reported by Amyand in 1736; by Morgagni in 1761, and in 1785.

Hevin reported in detail, a case of suppurative appendicitis in a sac of a femoral hernia. Hasselbach reported one in 1814; Taramelli one in 1835; Javanelli in 1836, and Cabaret in 1842.

During the first two decades of this century in the United States, Wildam and Keen reported an incidence of 0.9 per cent. Regnault found five cases of appendicitis in 889 operations for the radical cure of the hernia, an incidence of .56 per cent.

Agnes Seaston reported a case of gangrenous appendix in a strangulated hernial sac in an infant six weeks old; operation disclosed a complete gangrenous appendix inside the sac, while the lower pole of caecum which was engorged and discolored but still viable, was outside the sac.

Hodgson, reported a case of strangulated femoral hernia associated with an appendiceal abscess in the hernial sac, in a woman aged 70.

F. W. Milburn reported a case of herniated gangrenous appendix in an infant six weeks and six days old. Operation disclosed a swollen spermatic cord, filling and distending the right scrotum. A small hernial sac was dissected free, opened and found to contain an acutely inflamed appendix with a small gangrenous area at the tip.

MacMillan reported a case of gangrenous appendix in a femoral hernia in a woman aged 54. Watson collected 512 cases of hernia of the appendix, 269 were inguinal, 217 femoral, 2 obturator and 24 not stated.

Henry J. Lengston reported a case of strangulated hernia containing gangrenous appendix and the caecum, in a five weeks old baby. Charles M. Edlen in 1930 reported a case of appendix in the scrotum of an infant, eleven months old. Foster reported an isolated gangrenous appendix in a femoral hernial sac in a woman 66 years of age. Foster Smith reported a case of ileum, caecum and appendix, strangulated in left-sided hernia, in a man 24 years old.

The majority of the cases reported are in older people from 55 to 70 years. It must also be remembered that in the majority of the cases reported, the appendix and caecum were a part of the hernial mass. Strangulation of the hernial contents with incidental involvement of the appendix was another feature of rather common occurrence. Keen pointed out that in children the presence of the appendix in the hernial sac includes the caecum as well as a part of the hernial mass, while in adults, acute or chronic inflammation involving the appendix alone, is found. In this present case report the appendix was the sole organ found in the hernial sac.

REPORT OF CASE

Patient, Mr. M. L., entered the Dukes County Memorial Hospital August, 1932, with the following history: Eighty-eight years of age; has never had any serious sickness, felt remarkably well for his age; past history is of no particular significance to his present condition except for the fact that in the past two years the family noticed he acted strangely. His mental condition gradually became confused and he lost control of the acts of urination and defecation, making it necessary for one member of the family to wait on him in performing these acts. It was not possible to get any history directly from the patient on account of his senility and extreme deafness. At no time was any member of the immediate family aware of the fact that he had an inguinal hernia. The patient never made any complaint referable to that region and very little attention was paid to him by the family.

On the afternoon of August 11th, while one of his sons was helping him undress, he noticed a large mass in the right inguinal region which was painful on palpation and soon it was evident to the son that his father was in pain and distress even though the patient did not utter a word regarding his condition.

His family physician was called and made a diagnosis of strangulated inguinal hernia. An at-

tempt was made to reduce the hernia without success. The foot of the bed was elevated and hot applications applied to the inguinal mass and an opiate was given hypodermically. Four hours later I was called in consultation.

Physical examination showed a fairly well nourished old man, 88 years of age, apparently acutely ill. His tongue was very furred; neck and chest negative. The abdomen moved fairly well on respiration and no tenderness, rigidity, distention, or fluid were elicited. A round swelling, hard and tender, and the size of an orange, extended from about 5 cm. below the anterior superior iliac spine, to the pubic crest on the right side. This mass was dull on percussion and no impulse was noted on coughing. An effort was put forth to reduce the hernia, but this was futile.

His temperature was 100; pulse 106; respiration 22; blood examination showed 15,000 polymorphs; blood pressure 160/90. Urine examination revealed no sugar, no casts, a trace of albumin, and a few bacteria. It had an occasional blood and pus cell. The attending physician and myself felt that we were dealing with an irreducible strangulated inguinal hernia and advised an immediate operation. The patient was quickly removed to the hospital and the operation was immediately performed with the operative technique as follows: Under local infiltration anaesthesia, of apothesine, an incision was made in the right inguinal region, parallel to and above Poupart's ligament. It was soon found that the aponeurosis of the external oblique muscle and other fascial coverings were swollen and edematous. Careful dissection of the fascial layers continued, and upon reaching the sac proper and incising it, a large amount of foul pus was obtained. The odor was that of a colon bacillus type and the hernial sac contained a large, black, gangrenous mass which was adherent to the wall of the sac. The mass was recognized as the appendix, adherent to the wall of the abscess cavity, and was bluntly freed from its adhesion, and traced to its proximal end, where it was adherent in the neck of the hernial sac. A ligature was placed around the appendix very close to the internal ring and no attempt was made to free it at that site. The false membranous and redundant tissues which were in a state of necrosis were resected. A large hard rubber tube and gauze packing was inserted with no suturing of skin or other hernial layers. A generous hot compress was applied to the operative field and the patient was returned to bed; 1,000 c.c. of normal saline with glucose and soda was given subpectorally. The patient was put out of bed on the second postoperative day, and daily thereafter, in order to guard against hypostatic pneumonia. The wound drained very profusely during the first ten postoperative days and gradually thereafter the purulent discharge lessened and the wound healed firmly by granulation.

It is most likely no further operative, radical repair of the inguinal canal will be necessary. The patient was discharged from the hospital twenty-one days after admission.

The conclusion reached after the operation was that the appendix lying in the hernial sac had become inflamed and gangrenous, then perforated, resulting in abscess formation. In some cases the abscess had ruptured externally.

COMMENT

Hernial appendicitis is not common and usually occurs in subjects past middle life. The appendix is accompanied by caecum, small intestine, or omentum, in the greatest number of cases. Factors which govern the production of inflammation of the appendix lying in the hernial sac are similar to the intra-abdominal type of appendicitis; however, there is an added factor in these types of cases; that is, that the presence of the appendix in the hernial sac for a long period of time results in the formation of firm adhesions between it and the wall of the hernial sac, thus limiting the normal peristalsis of the appendix.

Foreign bodies entering the appendix, or other forms of irritations when they arise, cannot be overcome as easily, thus leading to infection, strangulation, and gangrenous formation of the appendix. The hernial ring is usually large in the cases where the appendix is associated with the caecum or omentum and usually the inflammation of the appendix is not of a very severe degree. This condition of the ring provides protection to the appendix from the pressure of the hernial ring, while in hernias containing the appendix alone, the hernial ring is usually small; thus constriction sometimes occurs and the appendix becomes irritated, resulting in adhesion to the sac wall. This interferes with its blood supply, favoring the development of an inflammation and infection which may lead to gangrenous formation with perforations and finally an abscess formation. This is true of the femoral type of hernia on account of the femoral ring being comparatively smaller than the inguinal.

Watson questions very strongly the accuracy of the reports diagnosed as purely strangulated appendiceal hernias, which he recognizes as being rare. Most of the cases reported as so-called strangulation of the appendix are, in his opinion, cases of hernial appendicitis. It does, however, seem logical and probable to assume that partial strangulation does occur, particularly in the isolated appendiceal hernias. A thick meso-appendix containing large, fatty lobules, favors strangulation. Other factors such as the dependent position of the appendix lying in the hernial sac, pressure from the edges of the hernial ring and the weight of the overlying viscera all tend to cause edema, swelling, and partial strangulation, leading to infection and terminating in gangrene and perforation.

Nearly all the reported cases of complete strangulation of the appendix were in cases where the

appendix was the sole content of the sac and in the femoral type of hernia. In the present case report, the appendix was the sole content of an inguinal type of hernia. An abnormally mobile caecum favors the development of left-sided hernial appendicitis and usually, in this type of cases, the appendix is much longer than the right-sided cases. A long meso-appendix or adhesions of the tip of the appendix to the testes or fundus of the sac in complete hernias, tends to favor the complete descent of the appendix. Usually, the entire appendix is found in the sac of caecal hernias; on the other hand, in cases of isolated appendiceal hernias, one-half to two-thirds lie in the sac. Inguinal hernias of the appendix are more common in males and femoral appendiceal hernias are more common in females. Strain, lifting, trauma, coughing, anything that increases the intra-abdominal pressure acts as exciting cause, while in certain individuals possessing certain abnormal anatomical peculiarities, such as abnormal mobility of the caecum, elongation of the mesentery, a very long appendix, general ptosis of the abdominal viscera, a marked relaxation of the abdominal wall, predispose to the development of hernia of the appendix. It is evident that when the appendix enters the hernial sac it is exposed to more trauma on account of its exposed position, than when it lies intra-abdominally and consequently there is more disturbance of its circulation which leads to swelling, edema, infection, gangrenous formation, and perforation. In the inguinal type the contractions of the abdominal muscles increase the trauma while in the femoral type the comparatively small ring, the sharp edges of Gimbernatis ligament, the movement of the thigh, predispose and favor the production of appendicitis in femoral hernia. Femoral hernia of the appendix is not as common as the inguinal type for the reasons that the ring is not constant and when present is much smaller than the inguinal ring.

Symptoms

The general symptoms of appendicitis in a hernial sac are fever, pain, general malaise, absence of rigidity of the abdominal muscles, and abdominal distention. Passage of feces and flatus, constipation also are present as obstruction does not occur unless caecum and colon become strangulated by the hernial ring. The pain in the femoral appendiceal hernia is sometimes referred to the hip joint and in some cases to the inner aspect of the thigh and as low as the knee joint, while in the inguinal the pain is referred to the scrotum. The infection in hernial appendicitis is localized, the temperature is not as high as in the abdominal appendicitis, and because of relatively less pain the operation is usually delayed until gangrene has developed.

Diagnosis

The diagnosis of appendiceal hernia is very difficult. If the hernia is reducible, a truss is usually worn and the patient is free from symptoms, but if the appendix becomes adherent to the sac wall, pain is usually complained of and also referred to the appendiceal region, associated with the epigastric distress followed by nausea and vomiting and the case is usually diagnosed as an abdominal appendicitis. If the hernial strangulation occurs it is frequently diagnosed as pure strangulated hernia. Of all the cases reported in the literature only .01 per cent was correctly diagnosed before operation.

Treatment

The treatment is surgical. The acute appendicitis is the one of importance. If the appendix is gangrenous and suppuration is present, the same policy of draining a closed abscess when operating in the abdomen should be followed. A good policy is to open the sac and remove the remains of the appendix as close to the ring as possible. No attempt should be made to expose the caecal end and to ligate normal tissues in cases of isolated gangrenous appendiceal hernias. The wound should be cleansed of all purulent fluid; membranes which are in a state of necrosis should be removed; drains of hard rubber tubing and light gauze packing should be applied, and the hernia repaired at a later date. In cases which do not progress to the stage of suppuration and abscess formation, the appendix should be traced to its caecal end and removed in the usual manner, and the hernia repaired in one sitting. Cases having the caecum and appendix in the hernial sac and the gangrene is beyond the tip of the appendix; occasionally it is better to make a second incision, preferably a low lateral rectus incision, after freeing the appendix and caecum from surrounding adhesions and drawing caecum and appendix up into the wound, then complete the operation as an abdominal operation for appendicitis. This method has been suggested and is being practiced by a few men; however, it is not free from danger. It is more than likely that contamination of the peritoneal cavity while drawing the infected appendix, and caecum, might take place. In this type of cases appendectomy is done in the usual way, then the caecum freed from its strangulation by freeing it from surrounding adhesions and replacing it in the abdomen; the wound is drained in the usual manner and repair of the hernia is left for a later date. In a few cases, separation of adhesions and enlargement of the hernial ring is advisable where it is necessary for such cases as mentioned previously, and keeping in mind the avoidance of spreading the infection. In cases where the hernial sac contains the appendix in a gangrenous condition but no pus free in the cavity, it is safe to enlarge the ring and expose the base of the appendix, then ligate it at its base through the ring and close the operation in the usual manner. There are several things of importance which one should make note of:

First—In these wornout and debilitated patients,

local infiltration anaesthesia should be the method of choice.

Second—Getting these patients out of bed early enough tends to prevent hypostatic congestion of the lungs and preserve the tone of the general circulation. As elevation of the patient's temperature indicates an unstable metabolic equilibrium, therefore, early getting out of bed is contra-indicated by the presence of such temperatures and an increase in pulse rate. It is more advantageous to allow these patients to sit in a reclining chair, particularly as soon as they feel themselves capable of the exertion incident thereto.

Third—Forget the hernia and treat the infection and the associated sequalae such as toxemia, dehydration, acidosis and other systemic complications incidental to the repairative procedure.

I report this case because in my practice it is rather unusual. I have had to operate on several cases of strangulated hernias, in nearly all ages, but never have had to operate on an adult 88 years old for a strangulated appendiceal hernia. I had no idea, prior to operation, that the appendix in this case was in the hernial sac. As far as I have been able to learn, this is the first case to be reported which possessed the unusual occurrence of ruptured gangrenous appendix with abscess formation in an inguinal hernial sac, in a patient so old.

MEDICAL POOR RELIEF IN GRANT COUNTY

E. O. HARROLD, M. D.
H. E. LIST, M. D.
E. F. JONES, M. D.
MARION

For the past year medical and surgical services have been furnished to the indigent of the three townships in the city of Marion on a contract basis with the fees based on the minimum of the regular fee schedule of the Grant County Medical Society. Discounts were given from this minimum of 25 per cent for general work and obstetrics and 50 per cent for surgery and ear, eye, nose, and throat.

With the advent of Reconstruction Finance Corporation funds in the county came also a Governor's Committee on Relief for the entire county. They took the profit out of the furnishing of food, fuel, and clothing to the indigent and felt that the profit must also come out of the furnishing of medical relief. They asked that the Grant County Medical Society submit a plan to do this, with the understanding that this was an emergency and that the question of funds in the county was critical.

The plan, as finally adopted by the society for presentation to the Governor's Committee, is not perfect and is not satisfactory in all of its particulars to everyone, but is a compromise which was acceptable to the majority and was finally unanimously adopted.

The essence of the agreement as stated in the first paragraph is good faith. It is based on a desire of the Governor's Committee and the county commissioners to furnish the best medical service possible at the least cost. The members agree to furnish the same type service to the indigent as they do to their private patients but with the understanding that they shall render the minimum of service in keeping with good medical or surgical judgment and that the service shall be rendered to only those cases in actual need of the services. Services that may be postponed or withheld without threat to life or important function shall not be rendered under the agreement.

The county is divided into eight districts, each of which includes a town and the surrounding territory. In the Marion district and in such other districts as may seem necessary there is to be set up a sick call headquarters where all calls for medical aid are to come. These headquarters are to be in charge of investigators who shall investigate the case, call the doctor if necessary, and follow the case through its entirety. Where the applicant for services has no choice of doctor, the doctors are to be called in rotation. There is a special fee schedule for this agreement which is from 50 to 75 per cent below the minimum of our former schedule. Any disputes are provided for by the setting up of an adjudication committee of two doctors and one layman who will review the case, and their decision is final. Bills are checked and if any question arises about the bill it is referred to the committee for settlement. Time alone will tell if this method of handling the problem will be satisfactory. Our only hope is that it will keep the practice of medicine in the hands of the physician, where it rightfully belongs.

The accompanying chart will show where the medical relief program fits into the total plan for relief in Grant County.

AGREEMENT

BETWEEN THE GOVERNOR'S COMMITTEE, THE GRANT COUNTY COMMISSIONERS, AND CERTAIN PHYSICIANS OF GRANT COUNTY

I. The essence of this agreement shall be good faith. It is understood that the occasion for this agreement rests on the desire of the Governor's Committee and the Grant County commissioners to see that the indigent sick and injured shall have the highest quality of medical and surgical services available at the least possible cost to the county. It is understood that the member physicians and surgeons shall undertake to render the same high type services to the indigent that they render to their private patients, but it shall be further understood that they shall render a minimum of service in keeping with good medical and surgical judgment and the community's reduced ability to pay.

II. It shall be the understanding that professional services shall be rendered only to such cases of illness and personal injuries as are truly in need of same and that the item of life saving shall weigh heavily in the decision, and that services that

may be postponed or withheld without a threat to life or important function shall not be rendered on this agreement.

III. It is agreed that there shall be eight districts in the county, as follows:

Marion and the surrounding district.
Upland and the surrounding district.
Fairmount and the surrounding district.
Swayzee and the surrounding district.
Converse and the surrounding district.
Matthews and the surrounding district.
Gas City and Jonesboro and the surrounding district.
Van Buren and the surrounding district.

IV. All calls shall first come to the Township Trustees. In the Marion District the Trustees shall not order professional services but they shall refer all calls to the Marion Health Center for investigations (except emergencies). If after investigation the Health Center decides professional services shall be rendered, they shall provide professional services as outlined in Chapter 6. In townships outside of the Marion District, the calls shall come to the Trustees and all investigations shall be made by the Trustees, and these Trustees shall arrange for professional services as outlined in Chapter 6. Emergency calls shall be answered irrespective of plan of calls.

V. The physicians of Grant County who shall agree to render such services on these terms shall sign triplicate copies of this agreement, one copy of which shall be given to the Grant County commissioners, one to the Governor's Committee, and one to the Secretary of the Grant County Medical Society. It is agreed that such services shall be strictly restricted to those physicians and surgeons entering into this agreement who shall in this agreement be termed member physicians.

VI. In each district where the applicant for services does not have any doctor of choice, the doctors shall be called in rotation and no discrimination shall be practiced. In cases of objection to the doctor during the progress of the case, the patient may have a change to any other member doctor so desired on consent of the adjudication committee provided for in Section VIII, and where no choice is expressed, the doctors shall be called in rotation. Should there be need for consultation, the patient shall have the consultant of his choice from among the members.

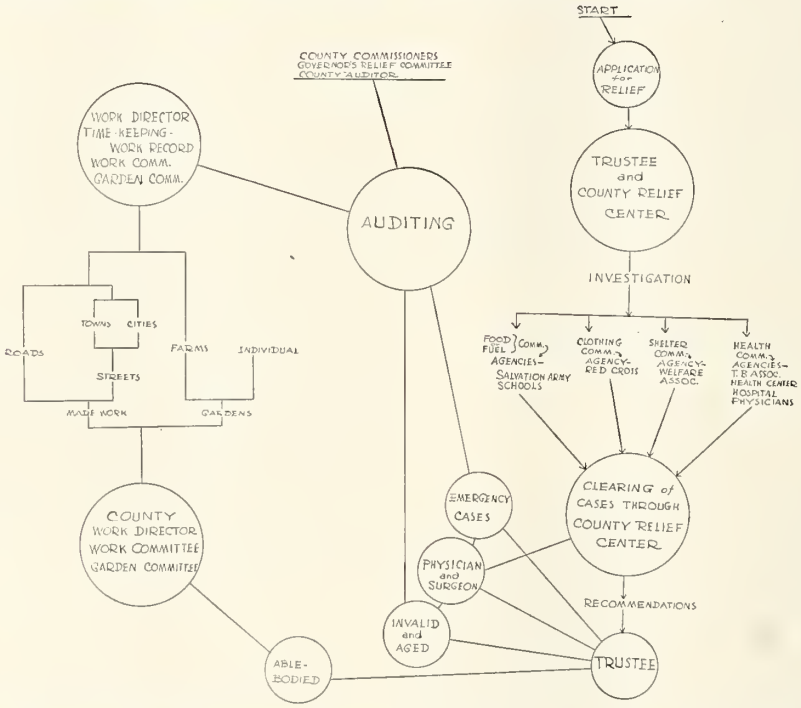


Diagram Showing How Medical Relief Program Fits into Total Plan for Relief in Grant County

VII. The following shall be the fees for services under this agreement:

1. This agreement shall run for not over one year.
2. Special conditions as shall arise under this fee schedule shall be referred to the adjudication committee who shall have full power to act.
3. All fees listed are flat fees.
4. No fee bill to be printed and no publicity given same.
5. Fee schedule to be submitted by a committee of two or three members and the commissioners told that this is an attempt to meet conditions, but that when conditions improve an increase must be made.

GENERAL WORK

Office visit—50 cents.
House visit—city, $1.25.
Night visit—city, $2.00.
Country visit—day or night rate plus 25 cents per mile one way.
Additional members of family—no charge.
Consultation—city, $2.50.
Consultation—country, $2.50 plus 25 cents per mile one way.
Administration of anaesthetic, $2.50.
Syphilis — intravenous, $2.00; intramuscular, $1.00.
Wassermann—state.

SURGERY

Abdominal operation—Surgeon, $20.00; assistant, $5.00. Includes care while in hospital. Care needed after at home, regular house call fee plus unusual dressings at cost.

FRACTURES

Nose—$2.50.
Clavicle—$5.00.
Humerus—$10.00.
Elbow joint—$10.00.
Hand bones—$3.00.
Foot bones—$5.00.
Ulna and/or radius except colles—$10.00.
Colles—$5.00.
Patella (open method)—$15.00.
Tibia—$10.00.
Tibia and fibula—$10.00.
Femur—$15.00.
Includes actual immediate work and while in hospital. Care needed after at home or in office—regular fees for these services.

AMPUTATIONS

Arm—$10.00.
Forearm or hand—$10.00.
Finger or toe—$2.00.
Thigh—$15.00.
Knee—$10.00.
Leg—$10.00.
Includes actual immediate work and while in hospital. Care needed after at home or in office—regular fees for these services.

DISLOCATIONS

Shoulder—$5.00.
Elbow—$5.00.
Hip—$10.00.
Includes actual immediate work and while in hospital. Care needed after at home or in office—regular fees for these services.

X-RAY

$2.00 per film regardless of size (not $2.00 per exposure or position).

EYE, EAR, NOSE AND THROAT

Foreign body, eye or ear—50c.
Paracentesis of ear (office)—$1.00.
Adenoidectomy, including anaesthetic—$5.00.
Antrum puncture and irrigation—$2.00.
Peritonsillar abscess—office or house call rate.
Acute mastoid—surgeon, $20.00; assistant, $5.00. Includes hospital care. Care needed after at home or office at usual rates plus unusual dressings at cost.

OBSTETRICS

Any case—$12.50.

VIII. The president of the Grant County Medical Society shall appoint two members and the Governor's Committee one lay citizen who shall be called the adjudication committee and who shall be permitted to hear and pass upon all points of controversy and difference of opinion and their decision shall be final. In case a call comes to an investigator or a trustee-investigator and he or she decides services are not required and do not fall within the meaning of this agreement, the interested parties shall be permitted to contest his or her decision by presenting the case to the adjudication committee whose decision shall be final.

IX. Bills for services under this agreement shall be rendered through such channels as shall be set up by the Governor's Committee.

Following is the plan of the Governor's Committee:

The doctors shall present their invoices in duplicate to the Township Trustee in a township where there is no official Health Center and a copy mailed to the Marion Health Center. The Trustee shall allow or disallow the invoices according to his judgment. In a township where there is an official Health Center, the doctors shall first present their invoices to the same for approval or disapproval. Invoices that have been disapproved by a Trustee or the Health Center shall be presented to the Adjudication Committee for its approval, change or disapproval and its decision shall be final except for the County Commissioners. Approved invoices shall be presented to the various Trustees who shall issue orders on the County Auditor. The County Commissioners have by law the right to question any invoice and this agreement does not seek to change or abridge this right. All invoices shall be itemized in detail. The Trustees shall retain the duplicate invoices for their records. The original shall accompany the Trustee's order to the County Auditor.

X. It is understood and agreed that all work done by the members under this agreement shall constitute a charitable act.

XI. By a majority vote of the Governor's Committee and the Adjudication Committee, in joint session, any of the above rules and regulations, except the fees, may be changed from time to time.

FEMALE SEX HORMONES*

MAURICE V. KAHLER, M. D.
INDIANAPOLIS

I wish to give a brief résumé of the literature on the part played by the hormones of the ovary and anterior pituitary in the sexual cycle of animals and the menstrual cycle of the higher monkeys and man.

There exist intricate and as yet poorly understood hormone inter-relationships of the ovary and other endocrine glands, particularly the anterior pituitary. However, with certain brilliant discoveries of the last decade this relationship is less confusing. I shall summarize chronologically these evolutionary steps as they have been discovered.[1]

Since most of this work has been done with animals it may be well to very briefly discuss their sex cycle. We find wide variations in time in the sexual activity of the various species; the hen ovulates daily, the rat has a four-day cycle, the pig a three-week cycle and the locust (cicada) a seventeen-year cycle. In many animals the cycle is marked by certain outward signs which in the female we call "oestrus." This periodic cycle is not always marked by outward signs. In the human species neither the desire nor the act of mating occurs at any specific time, but the periodicity of the cycle is marked by menstruation, the same being true of the higher monkeys. Rodents exhibit no outward signs of sexual excitement, but oestrus in these animals may be detected by vaginal smears.

The sex cycle of animals is characterized by regular, periodic, co-ordinated, histological changes in every portion of the reproductive tract. These changes manifest themselves especially in the growth, degeneration and regeneration of the epithelium of the uterus and vagina, and in the growth and rupture of ovarian follicles and the consequent formation of corpora lutea.[2]

The uterine endometrium of animals passes through a cycle of three phases, namely, rest, proliferation, and the progestational phase. In the higher monkeys and man we find the additional fourth phase, menstruation following the progestational phase.

The ovary passes through a cycle of follicle ripening and expulsion of the ovum, followed by a corpus luteum which may persist for a short or a long time depending on whether or not the ovum is fertilized. (Ovulation in the human probably occurs 14 to 16 days following the onset of menstruation.[3])

The proliferative phase of the uterine endometrium occurs concomitantly with follicle ripening and rupture, and the progestational phase occurs concomitantly with the corpus luteum.

Oestrus occurs at the time of follicle ripening and rupture in all animals studied to date, with the exception of the ferret, cat, and rabbit. The ferret and cat exhibit oestrus, the rabbit probably does not, but with none of them does the follicle mature and expel the ovum without the added stimulus of coitus.

With the higher monkeys and man the sex cycle, or in this case the menstrual cycle, is characterized by the absence of oestrus and the presence of menstruation. Menstruation does not occur in the sex cycle of the lower animals; the idea formerly held that oestrus and menstruation were one and the same thing is erroneous.

Workers for some time had been of the opinion that the ovary secreted a hormone, or hormones, and we find Frank and others with some experimental evidence to that effect. However, it was not until 1923 that we find E. Allen and Doisy and others publishing their paper showing that they had found the hormone of the graffian follicle.[4] Injections of this substance into castrate mice and rats induced the accelerated growth, hyperemia, and secretion in the genital tract characteristic of oestrus. This induced oestrus could be readily detected by vaginal smears.

In 1928 Doisy in this country, and a few months later Butenandt of Germany, announced the isolation of the hormone in crystalline form. The hormone is called folliculin and oestrin. Theelin (Thayer, Veler and Doisy), Menformin (Laqueur, Dingemanse and Kober), and progynon (Butenandt) are terms used by these investigators to designate the crystalline oestrogenic hormone which each has independently isolated. Other proprietary names for the same hormone are amniotin and estrogen.

The presence of folliculin is widespread. It has been demonstrated in small quantities in yeast and in the ovaries and other portions of many plants. In mammals it has been demonstrated in follicle fluid, in the corpus luteum, and in the placenta. It has been demonstrated in the blood; in the urine of normal and pregnant women; in the feces; in the bile; in the blood of males, and in other tissue fluids. The average potato, for example, contains from one to two mouse units of folliculin.[5]

From the observations of Born and the experimental work of Fraenkel, Leo Loeb, Bouin, and Ancel, it was evident that the corpus luteum secreted a hormone. Final proof was furnished by Geo. W. Corner, W. M. Allen, and others who published their first work in 1928. They carried out a series of experiments. In the first series Corner verified Fraenkel's and Bouin's and Ancel's work, and found that in the absence of corpora lutea the embryos died shortly after entering the uterine cavity.[6]

In the next series Corner and Allen removed the ovaries of a doe rabbit eighteen hours after a fertile mating, and at the same time removed a section of the uterus. They then injected a potent preparation of corpus luteum extract daily, and on the sixth day autopsied the rabbit. They found

* Read before the Indianapolis Medical Society, April 26, 1932.

by a comparative study of the portion of uterus removed at operation and a portion removed at autopsy that they had produced progestational proliferation of the endometrium.[7]

In later experiments they found they could remove a doe's ovaries eighteen hours after a fertile mating and by the daily administration of corpus luteum hormone carry the pregnancy to any desired length. They selected the fourteenth and eighteenth days to post the rabbits and found normal foetuses, normally implanted.[8] They were also able to produce artificial deciduomata with this preparation.[9] They called this hormone progestin, because its function is to prepare the uterus for the nidation of the fertilized ovum.

The clear-cut division of the ovarian secretion into two hormones with distinctive functions marked a definite advance. The problem of the individual functions of the two hormones has not as yet been completely solved. The known specific actions of the two hormones are as follows: Folliculin produces characteristic changes in the vaginal wall, uterus (production of proliferative phase), and mammary glands. It is responsible for the maintenance of ciliation of the tubes, secretion in the uterus and causes vasodilatation of the vessels of the endometrium.

The corpus luteum hormone has been found by Hisaw to produce relaxation of the pelvic ligament of the guinea pig, and resorption of the symphysis pubis of the pocket gopher. Corner, Allen, and others, as before mentioned, have found it produced progestational proliferation, is responsible for the continuation of gestation, and the production of deciduomata. Hisaw found it causes mucous transformation of the superficial layers of the vaginal epithelium of rodents. Papanicolaou and others succeeded in delaying or prevented the occurrence of follicle ripening and onset of oestrus by the injection of corpus luteum extracts. (Similar results, however, have been obtained with extracts of testes and extracts of other ovarian tissue.) Knauss and others inhibited the contraction stimulus of pituitary extract, however, folliculin has done the same.[10]

It has been found experimentally that the two hormones also act synergistically. Hisaw and Leonard have shown that their preparation of corpus luteum which they call "corporin" will not produce progestational proliferation until the mucosa is first acted upon by folliculin.[11] W. Allen was unable to produce the characteristic change in the endometrium of immature rabbits with progestin unless they first received injections of folliculin.[12]

That the two hormones act antagonistically, particularly if not given in the proper proportion and sequence, has been shown by W. Allen. Progestin loses its ability to produce progestinal proliferation in the castrated rabbit's uterus when it and very large doses of folliculin are given simultaneously, and that large doses of folliculin given the first five days after a mating prevents the development of proliferation, and if given the second five days after a mating causes extensive endometrial degeneration with sloughing of the endometrium.[13]

The higher monkey makes a valuable laboratory animal for comparative study of the human, because the menstrual cycle of each seems to be identical. An observation first made by Corner and later verified by E. Allen and Hartman is that monkeys sometimes menstruate in regular course without any preceding ovulation and corpus luteum formation. The endometrium in such cases does not show the progestational (or premenstrual) changes typical of true menstruation following ovulation. A few such observations have been made in women.[14] The conclusion, therefore, is that in primates there are two types of menstruation, one in which there is ovulation, corpus luteum formation and the proper development of the endometrium, and one in which they are absent.

E. Allen has produced bleeding in castrate monkeys with folliculin. However, the endometrium is in the proliferative and not the progestational stage.[15]

Hartman, Firor and Geiling were able to produce bleeding in adult female monkeys, both normal and castrates, and in baby female monkeys by injections of folliculin. They found, however, that hypophysectomy abolished this effect. With a preparation of anterior pituitary extract they were able to induce bleeding in hypophysectomized females, normals, castrates, and babies without the use of folliculin. Hartman therefore postulates a separate anterior pituitary hormone as the direct cause of bleeding. It was also found that *the threshold of bleeding was far below that causing oestrus changes (growth, edema and congestion in the uterus and ovaries)* and he raises the question as to the value of the mere induction of bleeding in amenorrheic women.[16]

On finding that although the endometrial changes of the lower animals and the higher monkeys and man are very similar, except that menstruation occurs in the latter, newer theories of menstruation have been postulated. We have been told menstruation represents a disintegration of the endometrium as a result of the decadence of the corpus luteum, or a cleansing or purging of the uterus in preparation for the on-coming ovum, or the abortion of an unfertilized ovum. Corner, after a study of the early human embryos and early embryos of monkeys, states: "My conjecture is this, that in order to provide for the highly specialized embryonic implantation of primates, . . . the endometrial process is carried so far as even to cause bleeding into the tissues during the last days of the interval, at the time during which the embryo is to be implanted. The action of the embryo alters the latter part of the process so as to inhibit or limit the hemorrhage; but if no embryo be present to utilize the extravasation, then the blood

escapes into the uterine lumen and externally visible bleeding occurs."[17]

We next come to the hypophysis as an agent in the sexual and reproductive cycle. This discovery in a way is revolutionary in that we learn of the profound inter-relationship between the internal secretions of the ovaries and those of the hypophysis.

That such a relationship exists has been known since 1901 when Frolich described his syndrome of hypopituitarism, adiposogenital dystrophy, and hyposexualism.

This was followed by extirpation experiments in young animals by which it was shown that the removal of the greater part of the gland caused defects in body growth, metabolism, and proper development of primary and secondary sex characteristics. X-radiation of the pituitary region in rabbits produced similar results.

Evans and Long, injecting extracts of the anterior lobe in young rats, observed greater rate of growth (increase in weight), delayed sexual maturity, lengthening of oestrus cycles, and in some cases oestrus was entirely inhibited.[18]

Smith and Engle, by making several daily transplants of the whole gland or of the anterior lobe only of mature rats into immature female rats, were able to produce oestrus in about one week after the transplantations were begun. This precocious sexual activity was brought about as early as the twenty-second day after birth. At the same time large luteinized follicles were developed in the ovaries. The results of transplants which precipitated oestrus were directly opposed to those of extracts which delayed it.[19]

We come next to the work of Aschheim and Zondek. They made use of single transplants instead of multiple, and obtained similar but more moderate results. The transplantation of a fresh piece of the anterior lobe into an infantile mouse weighing six to eight grams invariably brought about oestrus in three or four days. The vaginal smear was characteristic of oestrus, the ovaries showed follicle changes, and the animals were recognized by the male as sexually ripe.[20] With further work they state:

1. The hormone of the anterior lobe of the hypophysis, and only this, sets the ovarian function in motion and brings the infantile mouse to sexual maturity.
2. This hormone is present in both the male and female gland.
3. This hormone is still present in the female after the climacteric.
4. This hormone is identical in animals and in human beings.

The next experiment was a comparison of the effect of the anterior lobe hormone and the follicle hormone upon castrated adult female animals. The results were as follows:

1. Oestrin injected into a castrated female produced typical oestrus changes in the vagina and uterus. Oestrin injected into a normal female in the resting stage produced oestrus changes in the vagina and uterus, but no change in the ovaries.
2. Anterior lobe transplantation had no effect upon the vagina or uterus of a castrated animal. In a normal animal it caused oestrus changes in the vagina and uterus and ovulation and luteinization of the ovaries.

Therefore Aschheim and Zondek drew the following conclusions:

1. The hormones of the anterior lobe of the pituitary gland are the motor of the sexual function.
2. These hormones are primary, the ovarian hormones are secondary.
3. These hormones bring the follicular apparatus into action, discharge the ripening follicle, and mobilize secondarily the ovarian hormones in the follicle cell.

They found this hormone present in large quantities in the urine of pregnant women. It is present also in the urine and other body fluids of non-pregnant women, but in quantities too small to produce the characteristic reactions when injected into laboratory animals.

They injected small quantities of the urine of pregnant women into the circulation of immature mice and noticed characteristic changes in 96 hours after the first injection. These changes were:

1. Maturation of the follicles and the appearance of oestrus. (Anterior Pituitary Reaction One, April 1.)
2. Marked hyperemia and hemorrhage into the enlarged follicles. (Anterior Pituitary Reaction Two, April 2.)
3. The formation of corpora lutea, and the luteinization of corpora atritica (corpora lutea with imprisoned ova). (Anterior Pituitary Reaction Three, April 3.) These reactions, two and three, are utilized for the hormone test of pregnancy.[21]

Because Aschheim and Zondek in their test of pregnancy use five immature mice, a method which requires the keeping of a large number of animals on hand, and because working with such small animals causes certain technical difficulties, others devised simpler and easier methods. The simplest of all is probably the rabbit ovulation test of Friedman. (The rabbit not ovulating spontaneously.) Female rabbits of four pounds weight or over, which have been segregated for one month, are used. This segregation is necessary for one female hopped by another will ovulate. Five cubic centimeters of urine are injected into an ear vein, later a laparotomy or post is done and the ovaries examined.

If a laparotomy, the wound is sewed up and the rabbit is allowed to recuperate so that it may be used again a few weeks later. Various workers use a different number of injections, and the time interval between injections and examination of the ovaries varies with the different workers.

The accuracy of the test is remarkable. Aschheim and Zondek's results show an accuracy of 98.6 per cent (880 cases).[22] Several times the test was found positive as early as three to five days after the date of the expected menstruation.

The reaction becomes negative about the eighth day after delivery. (Wilson and Corner, using rabbits, report the reaction negative in 24 to 48 hours, and occasionally 72 hours.)[23] It has been found positive on the ninth and on the twelfth day after abortion. It remains positive as long as living placental tissue is in biologic contact with the maternal blood. Therefore, in tubal gestation we can expect a positive result only when the embryo is alive or not later than about eight to ten days after its death.

In hydatidiform mole (and chorionepithelioma) the reaction is strongly positive. Since there is no embryo in hydatidiform mole, it must be the living tissue of the mole that is responsible for the positive reaction. The test may remain positive after hydatidiform mole as long as two months, without evidence of chorionepithelioma. Corner reports a case which was negative in six days. The author in one case found the reaction became negative on the thirteenth day.

In a pregnant monkey the test was found positive. The urine of other pregnant animals did not give the reaction. So far the cow, the pig, the rabbit, the mouse, and the elephant have been studied.

Other workers have found the test negative in cases of missed abortion. It is positive in teratoma, tumors of the hypophysis, and chorionepithelioma of the male. From the literature it would seem that the test is positive also in a certain percentage of cases of rapidly developing tumors and cancer of the genital organs. Using blood serum instead of urine, the test has been found positive in women following castration and in a few cases of functional amenorrhoea.[24]

Recalling for a moment the various experiments I have mentioned involving the anterior pituitary, the extirpation experiments, the injection of alkaline extracts, the repeated and multiple transplants, and the single small transplants, we are aware of the contradictory results. Aschheim and Zondek finally isolated the gonad stimulating hormone or hormones from the anterior pituitary, and gave it the name, "prolan." (See foot note.) That which produced follicle ripening with discharge of ova they termed "Prolan A," and that which produced luteinization they termed "Prolan B." There is still some question as to whether these are two distinct hormones. Aschheim, Zondek, and others have proved that there is a growth hormone elaborated by the gland, and that it is antagonistic to prolan. Growth hormone should complete its work by the time of puberty, and prolan should then exert its influence for the first time. The anterior pituitary also elaborates a fat metabolizing hormone. Its exact status is as yet undetermined.

With the preceding findings in mind, and recalling the morphological events of the ovarian and endometrial cycles, we are ready for Zondek's final summation.

The female sex function manifests itself in the following ways:

1. The anterior pituitary is the motor of the sexual function and its two hormones are the superordinated hormones of sex.
2. Prolan A sets off the follicle ripening and incites the theca cells of the follicle to the production of folliculin, which in turn induces the proliferative phase of the endometrium.
3. Prolan B effects the change in the granulosa and the theca cells and incites them to the production of progestin, which changes the proliferative stage of the endometrium to one of secretion (the pre-menstrual, pre-gravid, or pro-gestational stage).

ORGANOTHERAPY

Substitution therapy has failed to keep pace with the new discoveries of female sex hormonology. With these discoveries the outlook is possibly brighter, but much confusion exists as to the clinical application of the hormones.

Therapeutists still make considerable use of ovarian extracts, whole ovary, corpus luteum, and residue. However, Frank and Novak have shown experimentally that such extracts contain but a minute quantity of active substance, the quantity often being so small as to produce no reaction upon the genital tracts of laboratory animals.

With the discovery of folliculin we have a preparation which produces a profound effect upon the genital tracts of these animals, but its clinical application has been a disappointment. In the final analysis the results obtained with folliculin are not in accord with many of the claims of the partly clinical and partly commercial literature of the last several years.

Graves states that some results have probably been obtained from the use of ovarian extracts and folliculin in the treatment of nervous disturbances related to the menstrual cycle, and that if such is the case, it probably means that this nervous factor is sensitive to even small doses of folliculin.[1] Frank, however, has shown that there is a certain group of cases with marked nervous symptoms who show an excess of folliculin in their blood.[25]

We may well be uncertain as to the dosage of folliculin, when we learn where Marion and Parks have shown that in the mouse two hundred units of folliculin, subcutaneously, are required to bring

Footnote: Evans, Meyer and Simpson (Relation of Prolan to the Anterior Hypophyseal Hormones, American Journal of Physiology, 100: 141, 1932) find the substance in the urine of pregnant women (prolan) inactive after hypophysectomy. To quote them, "We must think of prolan either of provoking the production of the gonad-stimulating hormone of the hypophysis, or as converting some inactive component in the hypophysis into an active substance."

on the full development of the endometrial change of oestrus. On a weight for weight basis, a woman would require two thousand times as much as a mouse, or four hundred thousand units to bring the endometrium from the resting to the proliferative stage.[26] It has been shown, however, that in the human large doses of folliculin inhibit ovarian function.[27]

It would seem that folliculin should be of value following complete removal of the ovaries. Smith and Engle have shown that the anterior pituitary hypertrophies following castration, and that the anterior pituitary of a castrate, when implanted into immature rats, has a more marked gonad stimulating effect than that of normals. Schoeller, Dohm and Hohlweg, by administering folliculin, were able to prevent the formation of "castration cells" in the hypophyses of rats after castration or to cause their disappearance with folliculin after they were present.[28] However, this may not necessarily hold true for the human.

Folliculin, being essentially a growth hormone, should be of value in increasing the size of an infantile uterus.

With the discovery of the hormones of the anterior pituitary it becomes apparent why folliculin is ineffective in amenorrhoea. To quote Graves, "Therapeutists of the past, working entirely in the dark, have wasted their energy in a feverish use of the extracts of the wrong organ."[1]

The only article found in the literature on the treatment of amenorrhoea with the pituitary hormone is by Campbell and Collip. They successfully treated three cases with Collip's preparation from the placenta.[29]

Novak, discussing the work of E. Allen (with folliculin), and Hartman, Firor and Geiling (with folliculin and the theoretical anterior pituitary bleeding hormone) on the induction of bleeding in monkeys, is of the opinion that such bleeding is not true menstruation but seems rather comparable to that occasionally observed in women in the interval period; i. e., the period corresponding to oestrus in the lower animals. Following this period in the human cycle, especially, there comes a prolonged up-building phase produced by progestin, which apparently possesses anti-ovulation and anti-bleeding properties. What causes the cessation of the progestin phase and the supervention of bleeding is not known.

We have found that the anterior pituitary hormones control follicular maturation, ovulation and corpus luteum formation, and that the cylic endometrial growth results from the ovarian hormones. Although the mechanism of menstruation is as yet unknown it would seem that amenorrhoea and oligomenorrhoea should be treated with the follicle stimulating factor of the anterior pituitary hormone (Prolan A) and functional menorrhagias and metorrhagias with progestin or the luteinizing factor of the anterior pituitary hormone (Prolan B). Progestin is unavailable, there being no potent preparations on the market. Theoretically, progestin should be of value in the treatment of dysmenorrhoea. It has been shown that progestin inhibits the contraction rate of the uterus. The pain of dysmenorrhoea is of a colicy type, suggesting spasmodic muscle contraction and it begins at the time the corpus luteum begins to regress. While various other factors undoubtedly play a role in the production of primary dysmenorrhoea (psycogenic, constitutional, developmental, etc.) the immediate cause would seem to be in a heightened irritability of the uterine muscle. On this basis, Novak makes a tentative suggestion as to a plan of organotherapy to be combined with measures directed toward other such factors as mentioned above.[30] (With progestin unavailable, Prolan B was used.)

We find that functional bleeding has been successfully treated with Prolan B. Novak and Hurd treated 51 cases with subcutaneous injections of a preparation of Prolan B obtained from the urine of pregnant women. In 44, bleeding was successfully checked. The failures were with a preparation of uncertain potency.[31] Zondek reports good results in such cases with Prolan B intravenously. Martin reports a series of twelve cases of various uterine hemorrhage treated with this substance in which he obtained good results in ten. Novak in discussing his cases called attention to the fact that the rapidity of the effect of prolan in many cases makes it seem certain that the immediate effect is not brought about through the production of lutein tissue and progestin by the ovary. He believes the immediate effect is exerted upon the still unknown bleeding factor. Geist reports 22 cases in which they gave repeated injections of Prolan B in women who were to be subsequently operated upon for some pelvic condition where they could obtain the ovaries. Some were injected two or three times daily for 13 days (a total of 1,400 units). Examination of the ovaries revealed no gross or histological changes.

We find as a result of experimental work we have obtained one and possibly two additions to our armamentarium which are of practical value. The first is diagnostic, the Aschheim-Zondek pregnancy test, and the second is therapeutic, the treatment of functional uterine bleeding. The former has been used extensively and has well stood the test of time. The use of the latter is more recent and limited. However, it seems to be of definite value.

Quoting Greenhill,[32] "It is best for the general practitioner to wait until the scientific investigator and the scientific clinician together have come to some definite conclusion about the value of hormone preparations in man. We have in this country a number of gynecologists who are at the same time excellent laboratory investigators and they are the ones who, during the next few years, will most likely help clarify the situation. Among the leaders are R. T. Frank, Novak, Fluhman, Graves, and

Mazer, and they have already shed a good deal of light on what we may expect in the way of therapy."

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THE CHIROPRACTIC SITUATION

FRANK JETT, M. D.
A. W. CAVINS, M. D.
TERRE HAUTE

This article is continued from page 172 in the May issue. Testimony of B. J. Palmer, president of the Palmer School, before the Supreme Court of Alberta, was presented; in the case of the State of Wisconsin vs. S. R. Jansheki, Milwaukee, 1910, Mr. Palmer testified that he had begun the study of chiropractic at twelve years of age, and was a practitioner of chiropractic at that age. The testimony in this case is continued:

Q. What education had you had up to that time?
A. Common sense.

Q. What education had you had at the time you began to practice chiropracties?
A. Common sense.

Q. None other?
A. Horse reasoning.

Q. Any other?
A. Good judgment.

Q. Any other?
A. That is enough.

Q. Who first put into praetice the seience of chiropractics?
A. My father.

Q. What was your father's profession at that time?
A. He was a magnetic healer prior to that.

Q. How did he first get the idea?

A. He explained (unquoted) that going into the Ryan Bloek, Davenport, Iowa, he met the janitor, who was very hard of hearing, and, as he was in a cramped position, they laid him down and gave some pressure on the back, and stated that that cured him of his deafness from then on.

Q. Chiropraetieally speaking, what is disease?

A. Chiropractically speaking, disease is simply a register as to the amount or exeess of eurrent that an organ receives at the end of the nerve. For instance, diarrhea shows too much force going to the bowel, partieularly to the rectum. In constipation there is not enough force going. It is simply a register of force at the same place in two different quantities; both being regulated by subluxation on the spine.

Q. Do you ask him for a history of the case?
A. No, because that would be of no value.

Q. What is the position of the chiropraetor in regard to what is commonly known as germ disease? First, let me ask you if the chiropractor recognizes any such thing as a germ disease.

A. I would have to say that the supposition is that the germ causes a disease, and the ehiropraetor recognizes no such condition.

Q. Take a case of blindness. Would you expect to find subluxation of the vertebrae?

A. (In part) The chiropractor, knowing the location of the effect, would trace out nerves over the eye, running back over the ear, tracing it down to the false circuit. When I am speaking of that, I am speaking of nerves not known in any of the anatomies. I am speaking of a distinct work traced out on the living and dead body. In other words, we have traced out the wires from where they are in the electric fan or in the globe to where they would lead clear back to the fuse box in the spine.

Q. Something was said about cranial nerves in connection with blindness. What do you say about that?

A. (In part) This involves a new set of nerves of which anatomy has no parallel.

Q. You say you have a system of tracing all your own?

A. We have.

Q. Does it differ from Gray's anatomy?

A. Very materially.

Q. Does it differ from anything else you have ever seen, heard or read of?

A. I might say this. The system of nerves that these and other photographs show, which we have worked out, are not portrayed or spoken of or displayed in Gray's anatomy or in any other standard anatomy, and I have fourteen in my library.

Q. Do you recognize reflex action?

A. Absolutely no.

Q. Do you recognize the sympathetic nerve system?

A. No.

Q. What vertebra would be subluxated if it was scarlet fever?

A. The twelfth dorsal.

Q. Then you say, do you Mr. Palmer, that scarlet fever, what we know as scarlet fever, can not exist as an effect unless there is a subluxated vertebra?

A. We can have no effect without a cause and subluxation is the cause and the scarlet fever is the effect.

Q. There can not be such a thing as diphtheria without a subluxated vertebra?

A. Subluxation must exist and then comes the diphtheria.

Q. Diphtheria is the effect or result of what subluxated vertebra?

A. The sixth dorsal.

Q. Do you believe one disease can be transmitted to another person through infection?

A. Not without there being a cause for it.

Q. What is the cause?

A. Subluxation.

Q. Then there is not anything in the germ theory that is inimical to health?

A. Not without the first consideration of a subluxation.

Q. Then do you not believe in infectious disease?

A. Not medically speaking.

Q. Is there a subluxation for syphilis?

A. Yes.

Q. Is syphilis transmitted through the germs?

A. No.

Q. Would you, as a chiropractor, put a gonorrheal germ in your eye?

A. I would not be afraid to do so as long as my spine is normal.

By the Council on Medical Education of the American Medical Association

"The text books used also are interesting. In anatomy the text used is said to be that prepared by Mabel H. Palmer, D. S., Ph. C. (1905), the wife of B. J. Palmer, the president of the institution. Court reports in 1910 show that the latter had only a common school education and had never matriculated in any school, college or university other than a chiropractic college * * *

"The low ideals of the leaders of this cult are shown in the report of Mr. Justice Hodgins, of Ontario, issued a few years ago. B. J. Palmer himself is quoted as having stated that bacteriology was the 'Greatest of all gigantic forces ever invented for ignorance and incompetency' and that 'The analysis of blood and urine is of no value.' In this same report other leaders of chiropractic deride also the study of materia medica and chemistry and state they have 'no earthly use for diagnoses.'"

From the foregoing you will understand the qualifications, beliefs and convictions of chiropractors asking to treat disease in men, women and children, with the consent and license of the State of Indiana. Let us consider the kindred branches of medicine, and compare the severity of their requirements with the laxity of the cults.

Requirements for the Indiana School of Dentistry*

Graduate of an accredited high school.

College course embracing chemistry, zoology, English, physics, psychology, German and hygiene.

The basic branches in:

First year:	160 hours	chemistry
	64 hours	dental anatomy
	280 hours	anatomy
	160 hours	embryology
Second year:	192 hours	physiology
	160 hours	bacteriology
	160 hours	pathology
	32 hours	hygiene

Last two years spent in the practical application of dental procedures.

The dental requirements, outside of high school and college work, total 5,124 hours.

Requirements for a Veterinary Surgeon

High school diploma from an accredited high school.

Five year course of nine months each, embracing the basic studies of chemistry, embryology, histology, pathology, pharmacology, parasitology, bacteriology, anatomy with dissection, zoology, botany, mammalian physiology, and veterinary surgery, hygiene and obstetrics.

[Is it not significant that the chiropractic "principle" has not been applied to veterinary medicine?]

Requirements for a Nurse in the Indiana University Hospital

Graduate of an accepted and accredited high school.

Perfect physical condition.

* Reprinted from The Monthly Bulletin of the Federation of State Medicinal Boards, July, 1920.

Spend three full years in training, with three weeks vacation each year.

Basic branches that include anatomy and physiology, bacteriology, hygiene, massage, dietetics, public sanitation and hygiene, laboratory, sociology, obstetrics and public health nursing. By law, a total of 500 hours of didactic instruction is required, besides the practical work, which includes bedside nursing, 5 to 6 months each in medicine and surgical wards, 3 to 5 months each in pediatrics, obstetrics and operating room, 2 months each in communicable diseases and nervous and mental cases, and 1½ to 3 months in public health work. The didactic work in the Indiana University Hospital actually amounts to 657 hours for each nurse.

REQUIREMENTS OF INDIANAPOLIS COLLEGE OF PHARMACY

Graduation from a commissioned high school.
Courses including:

First year:

Theory of Pharmacy—4 hours
Pharmaceutical Arithmetic—3 hours
Inorganic Chemistry I and II—8 hours
Plant Histology—3 hours
College English I and II—6 hours
Pharmaceutical Technology—4 hours
Descriptive Botany—3 hours
Physiology—3 hours
Total hours spent—822

Second year:

Pharmaceutical Latin—1 hour
Commercial Pharmacy I and II—4 hours
Manufacturing Pharmacy I and II—10 hours
Qualitative Analysis—5 hours
Pharmacognosy I and II—6 hours
Quantitative Analysis—5 hours
Total hours spent—846.

Third year:

Dispensing Pharmacy I and II—8 hours
Organic Chemistry I and II—6 hours
Bacteriology I and II—8 hours
Materia Medica I and II—6 hours
Economics I and II—6 hours
Total hours spent—828.

Fourth year:

Advanced Pharmacy I and II—8 hours
Drug Assaying I and II—7 hours
Biochemistry—3 hours
Invertebrate Zoology—4 hours
Psychology I and II—6 hours
Vertebrate Zoology—4 hours
Commercial Law—1 hour
Total hours spent—864.
Total hours required for entire course—3,360.

The details of a medical course are so familiar to readers of THE JOURNAL that we merely summarize the time spent:

Total class room hours spent in medicine—Approximately 6,500.

Total class room and study hours in medicine—Approximately 10,000.

I venture to say that these qualifications compare very favorably with the chiropractic standard. Why license the chiropractor and exclude dentists, veterinarians, nurses and pharmacists?

"Chiropractic" was founded in 1894, and we are unaware of any advance or contribution it has made to the diagnosis, treatment or prevention of disease in 39 years. Since then, in medicine have come control of yellow fever, malaria, plague, tuberculosis, hookworm and many others, the use of x-rays, the discovery of the organism of syphilis and its specific treatment, diphtheria antitoxin, scarlet fever vaccine, insulin and enough others to require a book to recount.

The World War has come and gone without a chiropractor, as such, in any army of the world. There are thousands and thousands of men in the veterans' hospitals of the world, getting along some way without the aid of chiropractics.

The legal representative of an industrial compensation insurance company appeared before the Indiana House Committee asking that they be excused from having to employ chiropractors in industrial work. The insurance companies of the United States, by whom health and death is counted in dollars and cents, do not employ chiropractors and are spending millions of dollars in advertising to prevent disease, and they recommend the way as taught in our state schools of medicine.

Go into the homes of the poor who are sick and unable to pay, and ask them who is taking care of them.

It has been charged that the medical profession recognized the chiropractor in Indiana in 1927 when the ones practicing in Indiana were licensed. This is not true. At that time all chiropractors in Indiana were practicing contrary to law. The law at that time was so weak that it could not be enforced and the chiropractor had acquired "squatter's rights." Today the law is ample to keep this from occurring again.

The medical profession has thoroughly agreed that it stands for all things that are for the good of society, regardless of whether they are good or bad for the medical profession. The Constitution of the United States affirms that the primary motive for government is the protection of life, liberty and the pursuit of happiness. The *protection of life* has a corollary, viz. the *preservation of health.* Medical men accept ideas and procedures that are good and true, regardless of source, but judgment in this regard is itself dependent upon the application of an ideal, namely: *There must be but one basic standard for those who would treat disease or administer public health.*

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MAY, 1933

EDITORIALS

ENEMIES OF SOCIETY

Time and again it has been reiterated that due to medical science the world has become or is becoming free of pestilences which up to not a great many years ago swept the earth at various times. The great plagues now return only in those regions where sanitary measures are not easy to control as in India and China.

Great advances of recent years have been made by research in surgical asepsis and technique, in preventive medicine, especially of tropical and parasite-borne diseases, and in the metabolic disorders. By study of nature's rules the secrets of natural processes have been discovered. This has been made possible because medical and biological investigators have used the same general methods of inquiry as have been used by chemical and physical investigators. Medical and biological sciences have kept pace with chemical and physical science.

There can be little argument against the contention that the medical sciences have been great benefactors of mankind. No one realizes so well as the investigator in medical science the possibilities yet to be accomplished. In the short fifty years past medical science has accomplished more than in all the centuries of foggy groping gone before. We are now, after a hard-earned beginning, on the threshold of more valuable service to mankind. More is expected of the investigator in medical science than ever before and many times greater needs be his preliminary training to develop an understanding judgment.

In an address before the New York Academy of Medicine, Dr. Walter B. Cannon[1] points out these things and brands any person or group of persons who stands in the way of advancement in medical science as an *enemy of society.*

There have always been quacks and charlatans living as vultures off the ills of people and to save their own destruction, hindering in every way the serious beneficent progress of the science of medicine: "magicians and medicine-men, tooth-drawers, horse-gelders and horse-leeches, witches, conjurors, sooth-sayers, hog-gelders, astrologers, holy-healers, sellers of magnetic tractors, and layers-on of hands." And now we must add to this infamous list of ignorant and stupid enemies of society who are attempting to hold back the progress of medical science the practitioners of Christian Science, chiropractic, naturopathy, the antivaccinationists, and, most subtlely dangerous of all, the antivivisectionists. Some of our large cities have numbered their public enemies, depending upon their importance in crime. So may our medical societies name the above as Enemies of Society One to Five.

The investigator of medical science and the practitioner of medicine and hygiene must leave his work in the laboratory and field to fight in the legislatures those who would prey on the gullibility of a public with a Middle Age mind and to protect the lives of helpless children from the fanatical stupidity of their elders.

[1] Cannon, Walter B. Scientific Monthly, Feb., 1933.

GABRIEL OVER THE HOSPITAL

The last trumpet was sounded for a hospital in this state the other day when it closed its doors insolvent. At that, hospitals have an enviable record compared to banks. Both have suffered what is quaintly termed "the predicament" and hospitals may even break the bank record if certain relief is not forthcoming. The R. F. C. has given largess to the helpless but in Indiana has ruled that no money whatsoever be paid to any hospitals. Senator Shipstead has re-introduced his bill in the 73rd Congress providing for such loans on the same terms as those given to financial institutions. Opposition to this act arises from the fact that hospitals have not yet done all they can to help themselves. The people still want an answer to the question: "Why don't hospitals lower their rates?" In some ways this is easy. Nearly half of the hospital expense goes for wages and they can be cut the 20 per cent corresponding to the decreased cost in wage earners' living expense. Foods are one-fifth of the total expense and the market price is much below previous levels. Equipment and surgical supplies are much lower and utility rates are either down or will be soon. Undoubtedly a hospital taking advantage of these factors can reduce its cost per day very materially, but even much more can be accomplished by intelligent internal re-organization and adjustment of overhead. During the lush years of shortly ago, we devised luxurious extra services to impress the patient and coddle the staff doctor. We should now realize that to save a few seconds' time is not so important when it costs money and that appointments need not be so elaborate especially

when the bill must be paid by the unfortunate patient and taxpayer. In many instances it is not the room rate that needs revision as much as the extra costs. A patient enters a five-dollar-a-day room and stays ten days. He naturally thinks the bill will be fifty dollars. Actually it is one hundred fifty dollars because he is charged thirty dollars for x-ray, fifteen dollars for operating room, fifteen dollars for anesthetic, ten dollars for nurse's board, ten dollars for drugs and serums, twelve dollars for laboratory tests and eight dollars for dressings. All of these extra charges should be scaled down. If the average cost per patient day in that hospital was five dollars the income from any one patient should not be fifteen dollars a day. A part of the trouble is due to physicians ordering excessive x-ray and laboratory examinations either thoughtlessly or to save the labor and time required to secure clinical evidences. A part is due to patients insisting on special nurses when floor duty would suffice. Panicky solicitude at times leads a family to incur obligations that are painful to meet when the crisis is past. The School of Nursing serves the purpose of supplying graduate nurses to a community, but the cost heretofore has been charged to the patient, a high tax paid only by the people who happen to get sick. Most schools now are discontinuing pupil nurse's allowances and are charging for the cost of books and uniforms and even a tuition fee, thus placing the burden more and more on the nurses who are the immediate beneficiaries. Most other schools are subsidized by the city or state. Hospitals must be maintained and the private patient should pay his own cost plus a reasonable profit, but should not bear all of the overhead and cost of the charity patients in addition. The latter is a community responsibility and taxes should be secured for the purpose. For example, a hospital costs one hundred thousand dollars a year. One-half of the patients are private cases and they should pay the fifty thousand; one-fourth are part-pay patients and they cost twenty-five thousand but pay only twelve thousand five hundred; the other fourth are pure charity and the loss is another twenty-five thousand dollars. The private patient should not have to pay the thirty-seven thousand five hundred dollar deficit because it is not his fault. The tax-levying officials will, of course, evade this if possible but the debt should be laid squarely on their shoulders. Neither physician nor layman should expect hospital costs to retreat to the pre-war level. Scientific progress has added to the complexity of the hospital day. Just as alkaloids succeeded crude drugs now ampoules supplant all others and subcutaneous and intravenous medication is expensive. The demands of the American College of Surgeons require a Medical Historian. Accredited hospitals must have a dietitian, a segregated obstetrical department and a full-time instructress, all of which add to the per diem cost. In the operating room we no longer work with bare hands nor prepare the raw catgut in coils. Gloves, sterilizer controls, tube catgut, gas and spinal anesthesia all have inescapably stepped up the costs. Compare the cost of a case of pneumonia in 1914 and now. In place of fresh air, expectancy and a few cents worth of strychnia tablets we have intravenous ampoules, typed cultures, serums and a thousand-dollar oxygen therapy apparatus. After a hospital superintendent has helped himself all he can by reorganizing, consolidating departments, eliminating luxury services, careful buying, supervised requisition of supplies, cuts in wages, etc., then he can turn to the public and justly ask for aid. A hospital is a basic humanitarian need in every community and should be upheld as long as the church and school house stand. The approach of National Hospital Day on May 12th marks a fitting time for re-educating the public. Don't criticise your hospital until you understand its problems and are giving your loyal support in leading it through this tragic crisis.

ANALGESIA IN LABOR

The true modern drama is enacted by the woman permitted to go through her labor without analgesic assistance.

Laboring women, classified upon the basis of analgesia they receive, readily fall into three groups: first, and a very small one because it represents an extremely modern turn, those few who receive analgesia throughout the entire labor; second, a much larger group, those who receive pain-relief only during the second stage of labor, and as general custom have it only during the latter half or fraction thereof—that is during the perineal or lacerating period or the stage of instrumentation; third, that vast majority who receive no analgesia at all.

Modern obstetrics not only includes but demands analgesia and anaesthesia. Shock prevention and surgical asepsis make them imperative, and with the mental and physical ordeal of child-birth increasing as civilization advances, the humanitarian demand can no longer be ignored. Medical science is morally obligated to extend the fullest application of the most perfected forms of analgesic therapy.

A striking discrepancy exists in human nature. If a woman is injured on a street corner a dozen men, including the street laborer, will spring forward to offer assistance and relief. If perchance the same woman should later be in labor in a hospital, probably listed as modern, it would not be unusual to observe that there she is permitted to endure, hour after hour, an increasing agony, finally concluding in a frenzied state of intolerable pain and physical exhaustion. Someone has correctly depicted her plight as that of an entrapped animal.

In great contrast to the service offered by the casual pedestrian we find ourselves as physicians

not infrequently standing idly and nonchlantly by, sometimes marking time in the corridor, or asleep in an adjoining room, preferably not too adjoining, or as occasion sometimes has it at home in our own bed, having left orders to be called when the head is on the perineum.

Why does a profession who holds its responsibility of relieving human suffering second only to that of detaining death react thus to the average woman in labor? Why does a profession whose science is traditionally and fundamentally free of discrimination seem so reluctant in obviating the eternal pain of child-birth? We of the noblest of callings in attempting an explanation surely feel the sting of defense, and probably intrench with the following: First, there still exists among large numbers of laymen and a few physicians the primitive and barbarous belief that for Biblical or other reasons the laboring woman should endure the pangs of her travail. Second, analgesia in obstetrics is a very recent science, it having been developed almost entirely within the life-time of the present generation. Third, until very recent years its degree of development made it applicable only to the second stage of labor, and if not properly administered might not only retard labor but sometimes incur mortality. Fourth, some of the most satisfactory methods are prohibitive because of cost, and are further greatly restricted by being excluded from home use because of cumbersomeness of apparatus.

For all that, our defense is weakened lamentably when we realize that for nearly two decades various practical methods of ameliorating labor pains have been freely taught in our medical schools, broadly practiced by leading obstetricians, abundantly described in medical literature, and because of popular interest occasionally exploited in lay publications. In short, from now on our chief intrenchment will be in the spirit of a Hippocratic diligence of purpose and enthusiasm for duty.

FEMALE SEX HORMONOLOGY

The subject of female sex hormonology is attracting much attention, and recent literature contains a great many contributions concerning it. Zondek, of Berlin, has written a comprehensive monograph on the subject, and many American contributions are little more than re-hashes of Zondek's work.

Female sex hormonology is a big field. Surgeons are constantly trying to correlate the pathology found at operation and in the laboratory with the clinical symptoms of the patient. Not much progress has been made thus far. The practical application of these new data probably will do much to clear up this uncertainty. In many laboratories an attempt is being made to diagnose these conditions on the basis of hormone disturbance. Considerable success has been attained in determining the causes of uterine hemorrhage and menstrual disturbances.

Heretofore, medical treatment has consisted of all sorts of hypodermic injections. Some felt that they obtained good results, others were skeptical. We have certain biological products such as insulin, whose physiological effects we have been able to determine. Improperly used, insulin is harmful. In this domain of sex hormones, we are not only able to make an accurate diagnosis but also to originate an effective treatment. The pregnancy tests are accurate in more than 90 per cent of cases. The tests are useful in many conditions other than suspected pregnancy. In cases of abortion or miscarriages, where the patient continues to bleed, this bleeding may be due to bits of placenta still attached to the uterine cavity; in these cases the pregnancy test is positive. In other cases the patient may come to the surgeon with a plausible story that would eliminate pregnancy as a possibility. A pregnancy test will protect the surgeon against the possibility of removing a pregnant uterus. Women, one or two years past the menopause, may become pregnant even in the presence of a fibromyoma of the uterus. A pregnancy test is helpful in making a correct diagnosis.

WHAT PRICE PUBLICITY?

It is noted in the *Literary Digest* of February 25, 1933, that Dr. Oliver T. Osborne has written an article in *The Medical Mentor* (New York), entitled "The Patient Pays." It also appears that a certain Dr. Roy H. McKay has published a book (for sale to the public), entitled "Let's Operate." Both authors, following almost a Sinclair Lewis pattern of caustic cynicism, endeavor to entertain (or amuse) the reader by holding up for ridicule the faults and foibles of the profession to which they belong.

It must be regretted indeed, by the sober-minded and straight-thinking members of our profession, that personal publicity seekers within our ranks have selected this most inopportune period to vent their ill-chosen and unkempt opinions. Dr. Osborne graduated in medicine at Yale University in 1884, lists himself in the American Medical Directory as limiting his practice to internal medicine, and claims fellowship in the American College of Physicians. Dr. McKay, by the same authority, graduated in 1906 from the Medical College of Ohio, Cincinnati, limits his practice to surgery, and is a fellow of the American College of Surgeons.

No intelligent doctor is stupid enough or asinine enough to believe that our profession is without its peccadilloes, its frailties, or even its imperfections. Yet, it reasonably may be questioned, what peculiar neurotic state of mind tempts a colleague to pose as a medical Moses leading the profession to a medical Utopia?

Exhibitionism results from an irresistible impulse to act in opposition to reasonable laws of decency; and, among 85 such instances studied by Seiffer, 18 occurred in epileptics, 17 in those who were demented, 8 who were neurasthenic, 8 who were alcoholic, and, of the remainder, 21 showed other mental abnormalities. Psychiatric examination is a kindly service to those so afflicted.

STAND BY!

The good ship "Organized Medicine" is in no imminent danger of foundering though at times she may appear to be in shoal waters. Her officers and crew, now that they are finally awakened to the many perils heretofore unnoticed along her charted course, are fully alive to the situation and they will see to it that she is safely guided into her home port.

We have had many bumps since '29; we have taken them in an upstanding manner; they have taught us new lessons and it is to be hoped that the knowledge thus gained will be of more than passing benefit to us; we trust we will not soon forget these lessons. Many things have contributed to what we believe to be a better understanding of our shortcomings and our various sources of strength but there can be no doubt that the now famous "Report" has done more to awaken us to a deeper sense of our responsibilities—yes, and to our shortcomings—than any other incident or series of incidents in many decades. It required just some such drastic thing to awaken the profession to cement a firmer union. In more than twenty-five years of activity in various medical organizations we have never known a time when our national, state and county societies have been so active; when their officers have given so much of their time to organization affairs; when so much of real good has been accomplished. West, Fishbein, and many others of the "home office" are getting about the country at a rate heretofore unknown; we read of them having been in Michigan one week, and in Oregon the next. They are doing monumental work and they are most certainly getting results. Nor is this activity limited to the A. M. A. group; most of the states, judging from reports in the various Journals, have an unusually active set of officers.

In our own Indiana we are surely keeping step; for the past few years we thought our officers had set an all-time record for covering the state; last year we were more than certain that President Crockett had placed the travel record so high that the mark would remain indefinitely; but President Weinstein and his "flying squadron" bids fair to equal that record and perhaps even surpass it. And the most portentous omen is that each of our county and district societies which sign up the squadron for a meeting asks that the subject of conversation shall be practically limited to medical economics, all of which means that we have at last awakened to the importance of that subject.

At the November Conference of State Secretaries and Editors one often heard the expression "The A. M. A. is ten or more years late in starting this sort of program." All state associations and every county medical society is guilty of the same charge—we are all late in starting our economic programs, but we have been going so rapidly that we have just about caught up with the procession.

All this activity costs money, as well as time; the latter is donated by those actively engaged in the various campaigns; the money must come from the general membership of the various organizations, and it should be borne in mind that this is no time for retrenchment, this is no time to reduce the collection of the sinews of war, meaning dues. The dues of our State Association—seven dollars—we believe to be the lowest of any comparable state association and it is absolutely impossible to carry on the present activities with less income than we have at present. By the same sign, there is not one single activity that we can afford to drop or even to curtail in the slightest degree. In fact, there are many more that we should take on if we but had the means. We are not unmindful of the fact that the dollar is today one of the most elusive things in America; we know full well the reduced incomes of the entire profession of Indiana; we know that most of us have about every dollar spent before we really get it in our jeans. All these things are more than fanciful, they are stern realities, but so also is the need for the annual contribution to our medical organizations.

Not so long ago we had a communication from one chap who is behind in his dues for 1932; he complained long and loudly about his present economic state; complained so efficiently, in fact, that we were about to become over-sympathetic and see what could be done about it. A little later we had the direct information that did this man but curtail his social activities to the extent of not more than fifty per cent he would be able to pay his medical society and hospital staff dues for more than one year.

The noon-day luncheon clubs, the various civic and fraternal societies, all have their places in the lives of professional men, but your medical society should have first consideration. Lest you may have overlooked it, we would suggest that all our members read the leading editorial in *The Journal* of the A. M. A. for April first. Editor Fishbein, at the specific request of the Board of Trustees, has made quite clear the position of that important group which is giving so freely of its time and talents to the furthering of the interests of the profession in America.

What most medical societies need at this time is a greater degree of support from their own members and very much less quibbling over the matter of local, state and national dues.

EDITORIAL NOTES

DEAR DOCTOR:

THE JOURNAL and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital.

We invite and urge you to use this Service.

It is absolutely *free* to you.

The Cooperative Bureau is equipped with catalogues and price lists of manufacturers, and can supply you information by return mail.

Perhaps you want a certain kind of instrument which is not advertised in THE JOURNAL, and do not know where to secure it; or do not know where to obtain some automobile supplies you need. This Service Bureau will give you the information.

Whenever possible, the goods will be advertised in our pages; but if they are not, we urge you to ask THE JOURNAL about them, or write direct to the Cooperative Medical Advertising Bureau, 535 N. Dearborn St., Chicago, Illinois.

We want THE JOURNAL to serve *you*.

IF you wish to present a paper before your section at the French Lick session, write to the chairman of your section; he may have a place for you. Every effort is being made to select worth-while subjects; perhaps your material is just the thing that is needed to complete the program.

ISOLATION never made a good doctor. He must give more than he receives. The biggest men attend the most medical societies..... The Democrats split things wide open in November. They closed 'em up in March, though *Jay County Medical Society Bulletin.*

Any county society wanting to know how much work is being done by the State Board of Health and the University hospitals for each doctor in the county may receive this information by writing to the executive officers of the institutions—Dr. John H. Hare, secretary of the Indiana State Board of Health, and Dr. E. T. Thompson, administrator of the Indiana University Hospitals.

HOSPITAL officials are harassed, as never before, by the crushing burden of financial distress. They need all the help they can get from the physician. Hospitals are our workshops and we have a right to direct their policies. It will be our own fault if we let them pass entirely under lay control through our own obstinacy or indifference. May 12th is National Hospital Day. Let every member of this Association celebrate by renewed co-operation and a sympathetic determination to lead his hospital back, if need be, into the path of more efficient and acceptable service.

A CLIPPING from a recent issue of the Delphi *Citizen* carries the statement that the physicians and druggists of Flora, in Carroll County, will have nothing to do with prescription liquor. They are reported as having gone on record as being opposed to the "prescription business in liquor." All of which is perfectly proper; individual physicians, or the members of a county society, have a perfect right to do as they choose in the matter. What most physicians complained of was the limitation by law as to the use of *any* remedial agent which, in their judgment, they might feel was indicated.

IN A recent letter from Henry Mencken, Editor of *American Mercury*, he makes this observation: "My interest in medical matters, I suppose, is due mainly to the fact that I live in Baltimore, and meet regularly a good many Johns Hopkins men." Which reminds us that once the layman becomes acquainted with members of our profession the better the opinion of the profession he has. Not so long ago the physician set himself apart, held himself aloof from the citizenry of his community, whether because of a feeling of superiority, an attempt to uphold what was then termed the dignity of the profession, or from some other cause, we do not know. But we do know that intimate contact with members of the profession by the general public usually increases the esteem in which they hold us.

THE cup that cheers but does not inebriate (we have the word of the Seventy-third Congress for this) is now with us; it came into the local territory soon after midnight of the day this is written. We have seen the product but have not partaken of it—this happens to be one of the coldest days we have experienced this spring and it is not conducive to beer drinking. Just what will result from this alteration of the National Prohibition Law remains to be seen. Certainly Indianians cannot go far astray, what with the various taxes and regulations with which its sale is being surrounded. Those living on the borders of neighboring states will witness a marked difference in the method of handling the beer problem. At this moment, *we are told*, just one long block from our business center and on the Illinois side of the "line," the bars are wide open and the customers are standing at least two deep, awaiting their turn at the spigot. Evidently thirteen years of home brew and spiked beer has created an intense thirst.

ELSEWHERE in this issue of the JOURNAL will be found a preliminary announcement of the postgraduate course to be given by the Indiana University School of Medicine under the approval of the Indiana State Medical Association. The need for a course of this type is urgent at the present time. It will offer physicians an opportunity to obtain the latest methods of diagnosis and treatment

at a minimum cost of time and money. With a vast wealth of available clinical material and an exceptionally well organized teaching staff, the Medical School would seem to occupy a position uniquely adapted for this type of study. A brief glance at the tentative program indicates the thoroughness, concentration and general interest of the course. Nowhere in the country is there available the opportunity to select in advance the type of graduate study in special subjects which the second week of the course offers, thus enabling an intensive review on the subject selected in a limited time. Every care has been taken to avoid unnecessary expense to physicians attending the sessions.

THE Indianapolis *Times* is to be congratulated for the manner in which it handled the recent story regarding the "discovery of the cause of cancer." Most metropolitan papers played up the alleged discovery in rather a sensational style; it remained for the *Times* to make some inquiries from the local profession, giving prominence to their statements. The five men who gave brief interviews on the subject are to be complimented for their statements; they were clear and concise, just such statements as are calculated to set aright the reading public. If and when we do make a real discovery regarding the cause or the cure of this dread disease, there is plenty of time to make public announcement of the fact. Granting that the men who gave the story to the press acted in entire good faith, the fact remains that more time for investigation might well have been given to the subject. A premature announcement regarding a matter of such vital importance is a most serious thing; this has been evidenced on numerous occasions. Practically all the great discoveries in medical science have been most carefully checked and found to be almost infallible ere they are sent forth to the reading public.

ATTENTION is directed to the forthcoming postgraduate meeting to be held at Richmond, June 1st. Chairman Murray N. Hadley announces a most interesting program; the instructors have been chosen for their teaching ability and many are internationally known. The meeting of last year was a decided success and the committee is making every effort to repeat this year. For several years there has been an insistent demand that postgraduate work be brought to the doors of our members and it is the plan of the committee in charge to select as meeting places the larger communities about the state, the first session having been held in Indianapolis. The future of the plan is, of course, dependent upon the support accorded and it is entirely up to our members as to just how far the committee shall go in planning these meetings. Richmond, at the extreme eastern part of central Indiana, is a most interesting city; it is one of the older communities of the state and has many historical associations. It is a bit out of the beaten path of most Indiana physicians, but a visit to that city will prove of more than passing interest. The registration expense is purely nominal, the plan of the committee being to raise only enough funds to pay the necessary expenses of the meeting. Full particulars may be obtained from Dr. Hadley or any member of his committee, the makeup of which is given in the committee list printed in each number of THE JOURNAL.

THROUGH a radical reorganization program of the Indiana State Board of Health, Dr. William F. King, who has been connected with that organization for twenty-two years, has resigned, and his post has been filled by Dr. John H. Hare, of Evansville. An explanation of the new set-up appears elsewhere in this issue of THE JOURNAL. Whether the retirement is due to the exigencies of changes in the political complexion of Indiana or to other reasons we are not prepared to state, but the service of two decades in such an important position deserves more than passing comment. Dr. King was most fortuntae in having been associated for twelve years with the former secretary, Dr. John N. Hurty, internationally known as a health officer, who did much to improve health, hygiene, and sanitation in our state. Dr. King introduced many of the now commonly accepted practices in health work and under his administration was developed the Division of Infant and Child Hygiene, with Dr. Ada Schweitzer in charge. There was also a marked increase in the activities of the office in connection with the various problems concerning food and sanitation. The regular inspection of the sources of milk and water supplies throughout the state were other laudable enterprises during his administration. Announcement of the retirement of Dr. King will be received with regret by his many friends over the state, all of whom will join with THE JOURNAL in wishing him well in whatever undertaking he may assume.

THAT the statesmanlike leadership of the headquarters office for the American Medical Association has saved not only the medical profession from socialism, but perhaps the American people from such a tragedy, was the belief of many of the physicians in Indianapolis and surrounding territory who had the pleasure of hearing Dr. Olin West, secretary and general manager of the American Medical Association, address the senior medical students at the Indiana University School of Medicine early in April; and who heard Dr. Morris Fishbein, editor of *The Journal* of the A. M. A., speak before the Indianapolis Medical

Society later on in the month. Both speakers dwelt at length upon the report of the Committee on the Costs of Medical Care, and both told how the committee by high-pressure salesmanship methods and ballyhoo had tried to "sell' the American public upon the panacea and the benefits that would come with socialized group practice based upon some plan of health insurance. In no uncertain terms Dr. West stated that "a free, untrammeled, qualified medical profession as opposed to a socialized system of service is the best means that the American public can have to maintain the quality of its health service." Both Dr. West and Dr. Fishbein insisted that the interests of the public and the physician are best guarded by maintaining present relations which exist between the physician and the individual patient, rather than attempting any system of practice which would undermine this relationship. The medical profession may be assured that as long as its destinies are in the hands of men such as Dr. Fishbein and Dr. West and other members of the headquarters staff of the American Medical Association, the interests of the individual physician and the American public will be protected.

A RECENT letter from a down-state member recalls to mind the fact that we do not hear so much about an annual health examination; some comments in the letter mentioned apparently afford an explanation as to why this particular campaign did not "go over so good." Quoting from the letter, "Everybody is recommending an annual examination for the recognition of beginning disease. In what does this examination consist? Your ear to the chest and an examination of the urine for albumen and sugar, and possibly a test for blood pressure and let it go at that, for a charge of two dollars?" His alternative question is whether there should be a really complete examination, this to be made for a reasonable fee. The letter and its questions are very much to the point; it comes from one of the older group, evidently a man who has taken his profession seriously and is desirous that we continue to carry on as in former times. There can be no doubt that many so-called health examinations were carelessly and incompletely done; we all know of many, many instances in which the patient approached the doctor with the idea of a complete checkup and emerged from the office with a puzzled expression, because his examination had been of the most cursory character. This would seem to explain why so many folks, living near the larger medical centers and taking seriously the frequently-offered advice to have a complete physical checkup, went to the larger hospitals, and were there put through the paces for a period of one to three days. Annual health examinations are just as important today as they were a few years ago; the average physician is well qualified to make a complete examination; there are numbers of our people who want such an examination; it remains for us to make such things possible. As to the fee, seldom will there be any objection to a proper fee after such an examination has been completed. It is quite like walking into a jewelry store to take advantage of the advertised "Eye Examinations Free;" then going to a competent oculist for a complete examination. There usually is no objection when the oculist presents his charge, for the patient is quite aware that he has had an examination and is willing to pay for it.

Southern Medicine and Surgery, March, 1933, has a very excellent article on "Some Unsolved Medical Problems," by W. M. Johnson, Editor of the Department of General Practice. He speaks of the many achievements of the profession in the past and of the vast amount of research work now being done; he advises that we do "not follow Alexander's example and weep because there are no more worlds to conquer." He then enumerates some of the problems before the profession at this time, which he would like to see solved:

"First, in spite of all the ballyhoo about cancer, the mortality from it is increasing. Before we can very well educate the public about this dread affliction, we doctors need to learn something about it ourselves.

"Second, the real etiology of hypertension, and a really scientific treatment of at least some cases of it.

"Third, the cause and cure of arthritis. Two of the best examples of its present unsatisfactory status are Dr. J. C. da Costa, the idol of Jefferson students, and Mrs. Charles Mayo. Each of these victims of arthritis is in a great center of medical progress and yet the condition of each has grown steadily worse in spite of all modern medical skill can do. Much work is being done on arthritis, and it seems as though we might see results soon.

"Fourth, a cure from the common cold. Recently some one asked Dr. Dochez, who is credited with tracing the malady to a virus, what he did when he himself got a cold. His reply was, 'I go to bed and stay there until I get well.' And that is about all anybody knows to do.

"Fifth, I would very much like to see our nose and throat specialists get together on a standard treatment for the ever-present sinus infection. No two of them, of my acquaintance, agree. Some operate early and often, some are conservative; some use vaccines and some do not; but whatever course is pursued, the patient with an infected sinus usually has a long and rocky road ahead. Substantially the same remarks may be applied to the treatment of otitis media.

"Sixth, the treatment of asthma and other allergic diseases leaves much to be desired. The skin tests have helped to some extent, but are by

no means the infallible guides to treatment it was at first thought they would be.

"Seventh, the leukemias remain to be understood. Just now I am watching a beautiful five-year-old girl die of an acute lymphatic leukemia, while her parents ask over and over, 'Isn't there anything that can be done to save her?' I am as helpless as if trying to put out a prairie fire with a squirt gun; even more so, for if discovered early enough, a prairie fire might be extinguished even with a squirt gun.

"Finally, the machinery for the legal testimony of psychiatrists needs overhauling. Nothing I know of does more to bring medicine into disrepute than the shameless bartering of reputations by men who, like Caesar's wife, should be above suspicion. I am sure that Dr. Hall and others of his character will join me in the wish that the time will come when experts in mental diseases will be paid equal fees by the state, regardless of the testimony given.

"These remarks are not written in a spirit of pessimism, but rather as a reminder that our profession is not dead, but very much alive, and with much work not only done but yet to be done."

ANY county medical society that desires a report upon cases, and the names of the referring physicians, from all of the University hospitals, may obtain this information by writing to Dr. E. T. Thompson, the administrator of the Indiana University Hospitals, at Indianapolis. This information has been made available to each county medical society as the result of an agreement between the Public Relations Committee of the Indiana State Medical Association, composed of W. P. Garshwiler, Indianapolis, J. B. Rogers, Michigan City, and H. L. Murdock, Fort Wayne, on behalf of the State Association, and E. T. Thompson on behalf of the University. Forms have been sent to each county medical society which may be used to request information along with a letter explaining the agreement. These forms and letters have been sent to each county society secretary with a request that this correspondence be read at the next society meeting following its reception. If any questions in regard to this agreement arise, write to Headquarters Office, 1021 Hume Mansur Building, Indianapolis, and the questions will be referred to the proper party. The letter from the Public Relations Committee follows:

April 11, 1933.

To the Secretary:

Numerous complaints have come to our committee in regard to the length of time patients are required to stay in the Riley Hospital and also in regard to the great number of patients received from some counties in the state. As a county is required to pay a per diem cost for each patient, you can understand that the total costs are somewhat large.

Your committee has carefully investigated these complaints and wishes to report to the State Association that the records show that the average clearance time of each patient at the Riley Hospital is approximately twenty-six days. The average stay of a patient in the Riley Hospital, by services, is as follows:

Pediatric	26 days
Surgical	34 days
Orthopedic	24 days
E. N. T.	8 days
Eye	21 days

As far as we have been able to find on investigation, the clearance time of other hospitals of comparable character runs from approximately sixty to ninety days. We think there can be no question but that the University hospitals will compare favorably with any hospitals in the country, that clearance is made as soon as possible for the best interests of the patient and the taxpayers, and we gladly commend the Riley Hospital management upon its efficient handling of its cases.

As to the justice of the complaint that the counties unnecessarily are sending in to the Riley Hospital so many cases that it is a burden on the taxpayers, your committee is not prepared at this time to render an opinion. The state law requires the University Hospitals to accept those patients who are ordered or sent by the county judge, and no one but the county judge has jurisdiction over this matter. The University Hospitals are in no way responsible for this condition. We have given this matter considerable thought, trying to visualize the problem from all standpoints, and we recommend the following to both the Medical Association and to the hospitals:

First, upon request of the secretary of any county medical society, or the county judge, the administrator of the hospitals will send to either a report of all cases referred to the hospital group (Riley, Coleman and Long) from that county. This report will be for the period requested, one month or longer, and will give the name, period of time of confinement, and the physician's name who referred each case.

Second, upon request, the administrator will report the progress of any case confined in any hospital in the University group to the judge or to the referring physician, and in case of slow progress the reason for same.

We are exceedingly glad to report the fine spirit of cooperation which we have had from both the hospital group and the State Association.

Yours sincerely,

PUBLIC RELATIONS COMMITTEE,
Indiana State Medical Association.
W. P. Garshwiler, M. D., Chairman.
H. L. Murdock, M. D.
J. B. Rogers, M. D.

THE PRESIDENT'S PAGE

Indiana, I feel, can take just pride in the part her physicians played in accomplishing legislation repealing the non-service connected disability injustice. President Roosevelt deserves great praise for his fearless and just stand on the question.

VETERAN NON-SERVICE DISABILITY

The indefatigable work of our past-president, F. S. Crockett, on the Liaison Committee of the American Medical Association, and the testimony given before the Shannon Committee at South Bend last summer, were outstanding mile-posts in bringing before the veteran's administration, Congress and the President, pertinent facts setting forth the injustices being done to physicians, the veteran and the citizen.

For approximately nine years the physicians carried on the fight, for seven years practically lone-handed. The past two or three years they had competent allies in the U. S. Chamber of Commerce, the National Economy League and other organizations. At last, with ammunition at the front scarce, and supplies in the S. O. S. exhausted, old General Depression was able to force the armistice on terms dictated by President Roosevelt.

In our own state some of the problems which have been disturbing us for years have bright promise of being solved satisfactorily to all parties concerned.

UNIVERSITY HOSPITALS

A much more cordial feeling exists between the University and the physician than has existed for a long time past. The entrance of patients from outlying districts into the University hospitals will be better controlled. Also there is reason to believe that soon there will be no private patients in the University hospitals, but only patients that are used for teaching purposes. A law was passed at the last session of the legislature which allows the judge to assign patients to a local hospital under the same ruling by which they have previously been assigned to Riley Hospital.

STATE BOARD OF HEALTH

A very radical reorganization of the State Board of Health has been accomplished by the Governor. While the Governor had fully made up his mind on the general plan of reorganization, yet he freely consulted the profession on many phases. There was a list of some fifteen names of doctors to fill the position of Commissioner. The Governor had selected some, his political advisors had suggested some, and others were by personal application. Our association took no hand in making up this list. The Governor had determined to appoint a young man and all those unfortunate enough to be not so classified were not considered.

We feel that his selection of Dr. John H. Hare has been very fortunate, both for the state and for the doctors. Dr. Hare is a young man, well educated, well grounded in his profession, and with experience in public health work, having been for some time a member of the Board of Health. He is honest, conscientious, fearless and fair. He is an ardent worker in the state association and has been for years, is not connected with any faction, and never has been concerned in any factional dispute. He is councilor for the first district, and highly respected in his home town of Evansville.

The University will have charge of all the scientific work of the board, and I can state without fear of controversion, after conferring with Dean Gatch, that the profession of Indiana can hold up its head and say that there will be no competition in the practice of medicine by our State Board of Health.

The great opportunity has now come to the doctors of Indiana. The purpose of the board is education in health matters, institution of public health rules and preventive medicine, all with police powers. The board will abstain from medical practice, if we, the physician, will give it reasonable support in its preventive medicine and education program.

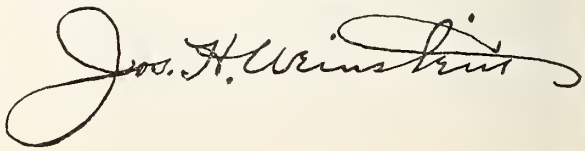
It is the intention to give us, the practicing physician, through the county society, the chance to take the initiative in these matters in each locality.

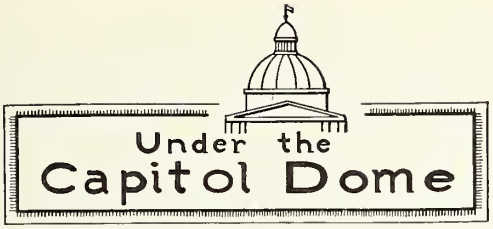
Doctors, what we have asked for, we now have. It is said that opportunity knocks but once at each man's door. Let's grasp this opportunity and cooperate with the State Board, the University and the Governor.

POSTGRADUATE WORK

Read the announcement of the postgraduate course on page 248. This will not interfere with the postgraduate course given by the University.

The Scientific Program Committee has been hard at work and has outlined a most interesting program for the French Lick meeting. Arrange to go down Saturday or Sunday for a day or two of vacation, and be ready for the meeting on Monday, Tuesday and Wednesday, September 25, 26, 27. You won't regret it.





Paul Fry, excise director, has issued a ruling which will allow physicians of Indiana to purchase and possess whisky for emergency medical purposes. The following letter was received April 21, 1933, by E. C. Yellowley, supervisor of permits, Bureau of Industrial Alcohol, Chicago, Illinois:

"In answer to your wire with reference to issuance of permits to the physicians, dentists and hospitals.

"This department has ruled that physicians, dentists and hospitals are entitled to purchase the amounts of spiritous liquors which they are permitted to purchase under the terms of the Federal Act or supplemental amendments thereto. Physicians and dentists, etc., will file with the State Excise Department applications on the same form used by druggists and enclose with their application to us remittance covering stamps and upon approval of the application by this department the stamps will be forwarded to them with the approved application and a copy of the same furnished to the wholesaler by the applicant. Such applications are now being received and permits issued.

"The regulations, shortly to be promulgated will read as follows: 'The director rules that a duly licensed physician, dentist, hospital, sanitarium or clinic, may purchase of the proper permit holder and possess and dispense spiritous liquors and pure grain alcohol at such physician's or dentist's office or in the establishment of a hospital, sanitarium or clinic for the use of bona-fide patients as incidental to medical care and or treatment of such patient, but not to be sold as such and subject to such regulation covering the same as may be now in force or hereafter promulgated under the National Prohibition Act.' "

On April 21st, the following telegram was received from Mr. Yellowley: "Excise director State Indiana advised me today that physicians, dentists and hospitals that state may obtain intoxicating liquor for administering to patients under federal and state permits. Forms seventy-four and fourteen ten may be filed with this office for consideration." Recent federal legislation has liberalized the rights of the medical profession relating to the prescribing of medicinal liquors. Word has been received that Dr. William C. Woodward, director of the Bureau of Legal Medicine and Legislation of the American Medical Association is in Washington engaged in cooperating in the framing of the new regulations which will be promulgated to control the prescribing of medicinal liquors. As soon as these new regulations are promulgated the medical profession will be promptly notified.

* * *

The Indiana Pharmaceutical Association has expressed its willingness to cooperate in the matter of unlicensed and unauthorized physicians writing prescriptions in violation of the law.

* * *

Charges were preferred against John R. DeRoan, a drugless physician who was convicted in Marion Criminal Court for producing an abortion which caused the death of an Indianapolis girl. DeRoan has been cited to appear before the Board of Medical Registration, July 11, 1933, to show cause why his license should not be revoked.

* * *

License to practice drugless healing was denied an applicant when it was shown that the young man was a minor, approximately fourteen years of age when he obtained his diploma from a drugless school. Affidavits from three Indianapolis citizens were presented, stating that on January 1, 1927, the young man was actively engaged in the practice of Naturopathy. The board held that because of his immature age, the spirit of the law had not been complied with, and license was denied.

* * *

Examinations for license to practice medicine will be held in the House of Representatives, State House, June 20, 21, 22, 1933. One hundred twenty-five applicants are expected from medical schools in Chicago, St. Louis, New York, and Indianapolis. Examinations for license to practice podiatry will be given in the Senate Chamber, State House, June 8, 1933. The board of medical registration administers the podiatry law, appointing annually two physicians from its own membership and two practicing podiatrists who, with the secretary of the medical board, constitute the Board of Podiatry Examiners.

* * *

Physicians who have occasion to appear before the industrial board as witnesses in compensation cases probably will be interested to know that the Governor is contemplating reducing the membership of the board from five to three. Some persons maintain that this would result in materially slowing up the process of hearing the compensation cases and might result in all cases being heard in Indianapolis at the Statehouse. The Governor, however, has not announced that he contemplates a change in the method of holding the hearings in various parts of the state, and has expressed the belief that three members can conduct the business of the industrial board, as efficiently as five.

The exact method of complying with the new Indiana income tax has been outlined for physicians by Clarence Jackson, director of the gross income tax division. Payment of the Indiana tax, after all, is a relatively simple procedure. Here are the salient points to remember:

1. The first payment is to be made before July 15.
2. This payment covers all receipts for the months of May and June.
3. Payment of tax is to be only on actual collections, not on accounts receivable.
4. The tax is collectable on all moneys received, whether for fees or other sources of income, excepting only all money derived from the Federal government, whether from pension or other Federal sources.
5. Exemption for the first quarter will be $166.67. Thereafter the exemption will be $250 a quarter.
6. Checks, cash or money orders will be accepted and checks do not need to be certified.
7. Checks should be made out to "Gross Income Tax Division, C. A. Jackson, Director," and mailed to the Statehouse.
8. A form, which will be provided, must accompany the tax payment.
9. The tax will amount to one per cent of the total income, minus the deduction. The total exemption provided by the law is $1,000 a year.

There is still some uncertainty about the printed forms which will be provided all persons paying the tax. They have not yet been worked out, but will be ready in time for the first tax payment, according to Mr. Jackson.

The method of distributing the forms also remains to be worked out. They probably will be distributed through the county treasurers of the various counties, but this has not been definitely determined, according to Mr. Jackson.

The income tax law provides that persons who earn more than $5,000 a year must pay quarterly, while those earning less than that amount may pay once a year. However, all persons in the state are to pay this quarter, regardless of the amount of money they earn annually, according to the income tax director. The schedule may be revised later, but this is the way it stands now.

MEDICO-LEGAL DEPARTMENT

By
ALBERT STUMP
Attorney for the Indiana State Medical Association

QUESTION: How are the Long, Coleman and Riley Hospitals operated and maintained?

ANSWER: The Long Hospital was built upon grounds donated by Dr. Robert W. Long and accepted by the state in accordance with the Acts of the General Assembly of 1911, page 15, which act was later amended and enlarged by the Acts of the General Assembly of 1913, page 12. The real estate donated by Dr. Long was considerably more extensive than was required by the hospital itself, and funds were later raised through bonds secured by mortgage on the real estate. Under the Acts of which the hospital was established it was placed under the control of the Board of Trustees of Indiana University as part of the Medical School.

The act creating it authorizes it to be operated as a charity hospital and also to receive paying patients. Where one seeks admission as a charity patient the application must be signed by his attending physician and certified to by the township trustee of the township in which he resides, on forms supplied by the hospital. There is no charge made for charity patients to the county or township of which the patient is a resident, but the expenses of maintaining and operating the Long Hospital which are not realized from paying patients are paid out of funds appropriated by the state.

The Coleman Hospital for Women was made possible through a gift from Mr. and Mrs. William H. Coleman of $250,000 in real estate and securities. It was built on grounds of the Long Hospital and was offered to the Trustees of Indiana University in 1924 and accepted and placed under the control of the Board of Trustees of Indiana University by an act of the legislature of 1927 (page 607.) This Hospital is for women only, and patients are accepted as paying patients and also as charity patients. The charity patients are admitted on application signed by the attending physician and certified by the township trustee. The cost of maintaining the hospital, above what is realized from paying patients, is paid by state appropriations.

The Riley Hospital is for children under sixteen years of age. It is under the direction and control of the Board of Trustees of Indiana University and was built and is maintained largely by charitable gifts which are supplemented by state appropriations and also by the cost collected by the hospital for the care and treatment of its patients. The hospital is open to any child under sixteen years of age under such rules and regulations as may be adopted by the Board of Trustees of Indiana University. The judges of circuit, criminal and juvenile courts of the state are empowered to commit to the hospital any child having legal settlement in the state who shall appear to the satisfaction of the judge, after public hearing, to be suffering from a disease, defect or deformity which may be benefited by treatment in the said hospital, and whose parent or legal guardian is not financially able to defray the necessary expenses for such treatment. The hearing is had on a petition filed before the judge by any citizen of the county of the child's legal settlement, and the hearing is in the presence of the parents or legal guardian

and prosecuting attorney of the county. The judge may, in his discretion, have the child examined by one or more reputable physicians who make and file a written report of the history, condition and probable result of the treatment of the child. If the judge finds on such hearing that the child is a proper subject for treatment in the hospital, he may commit the child to the hospital and the clerk of the court then makes an application for admission on forms furnished by the Superintendent of the Hospital. If the application is accepted the Superintendent notifies the clerk informing him when the patient may be received and the judge then provides some suitable person to accompany the child to the hospital. The cost of the care and treatment of a child committed by the judge is paid by the county in which the child has a legal settlement. The management of the hospital keeps an account of the costs of the treatment, and a certified statement is rendered quarterly to the Auditor of State, who issues his warrant on the Treasurer of State, and payment on the warrant is made out of the general fund of the State treasury. The Treasurer of State then reimburses the general fund for the amount so paid out by collecting from the county a like amount in the next succeeding semi-annual settlement with such county. No compensation is charged or allowed to the physician, surgeon or nurses for the treatment or care of any patient committed by the judge to the hospital, other than the compensation paid therefor by Indiana University.

While under the Acts of 1921, page 833, (Burns 1926, Sections 7150 to 7159) patients may be admitted in accordance with rules to be adopted by the Board of Trustees of Indiana University as well as commitment of the courts, yet in the experience of the hospital all patients have been admitted upon the commitment of courts and applications for admission are all signed by judges. The number applying for admission under such conditions has been larger than the capacity of the hospital to care for.

Where the hospitalization is necessary in the care of the poor and is provided locally, it is charged against the township in which the poor person has his settlement. But as shown above, where the hospitalization is obtained through the Riley Hospital it is charged against the county. Where hospitalization can be obtained satisfactorily locally it is possible that it may be obtained at a lower cost in many instances and the result would be favorable to the local taxpayer, even though in the one instance it was paid from county funds and in the other from township funds. Both funds are derived from the same source. Judges and trustees, no doubt, would be glad to cooperate with physicians in taking care of the situation in the most satisfactory manner, but they are not always advised as to the legal methods through which the most satisfactory and economical results might be obtained.

SECRETARIES' COLUMN

On June 26, 1933, during the course of postgraduate instruction that will be given by the Medical Department, Indiana University School of Medicine, the county society secretaries of the state will meet at the University at 5:30 in the afternoon. This will be a very important meeting. At this time each county medical society secretary will learn what his duties will be in connection with the work of the State Board of Health under the new organization. The June issue of THE JOURNAL will contain more details.

Last month I enjoyed an interesting talk by Dr. Morris Fishbein, editor of the *Journal* of the A. M. A., at the regular meeting of the Indianapolis Medical Society.

His talk on socialized and state medicine is food for thought for every physician. Every county medical society secretary should have heard this discourse. Every county society secretary should continue to urge the members of his society to stand by the Minority Report.

The report of the Committee on the Costs of Medical Care was produced by a group of men hand picked by Mr. Filene. They had written on this subject and they made the report fit their own ideas.

Dr. Walter Kelly's article on "Scientific Papers," as published in the *Bulletin* of the Indianapolis Medical Society for April, is worth reading. It will guide a great many doctors in their preparation of a paper for the medical society.

The 40 and 8 are waging a fight against diphtheria. They boost the family doctor and city clinics. I believe the medical profession should watch this movement so that they can keep the practice of medicine in the hands of the doctors. I believe they mean right but there is always a chance for a slip.

COUNTY SOCIETY SECRETARIES: Please be sure to answer the questionnaire sent to you by the Special Committee on Medical Care of the Indigent. If each secretary does his part, a valuable collection of information will be obtained. Replies should be sent to A. W. Cavins, M. D., 674 Cherry Street, Terre Haute, Indiana.

Dr. Hare, of Evansville, councillor for the first district, should make a good secretary for the State Board of Health. He is honest and firm in his convictions. We wish him success.

Did you read the article in the *American Mercury* for March by H. L. Mencken on the Costs of Medical Care? THE JOURNAL abstracted the article. You should read the layman's point of view in full, which is good. You should have this article read at your society meetings.

At the last Secretaries' Conference in January a resolution was passed condemning the American College of Surgeons for fostering contract practice.

In the near future, I will have some correspondence to put in this column concerning this resolution.

STATE BOARDS OF HEALTH

I understand that the Secretary of the State Board of Health in one of our neighboring states is also the secretary of his state medical association and editor of *The Journal*. What a political set up he has! What a deplorable condition for that state! Thank God we are free of such a condition in Indiana; and I hope the medical profession in Indiana will never let such a thing happen in this state.

SOCIETY PICNICS

How many societies have planned a picnic for this summer? Good thing to do; think about it.

POSTGRADUATE COURSE

Do not forget the post graduate course given by the State Association to be held in Richmond, Indiana, June first. See announcement on page 258 in this issue.

DUES

Every county society secretary should make an extra special effort to collect county society dues from delinquent members before the start of summer when fishing and vacationing become naturally paramount interests in the minds of his colleagues. It is just as easy to get a malpractice suit for services rendered in the summer time as in the winter time, and until a physician's dues are paid he is running the risk of being threatened with a malpractice suit and going undefended for any services that he rendered during that part of the year when his dues have not been paid.

A. M. MITCHELL, M. D.

Diphtheria Report for March, 1933

Thirteen diphtheria deaths for March show an increase of three over the month of February of this year, and two over the month of March of last year. In March, 1931, there were six deaths, and in March, 1930, there were five deaths. Even so, however, we are still below last year's rate at this time. Last year for the first quarter there were fifty-three deaths, and this year there have been forty-one. The following counties entered the black list for the first time: Bartholomew, Blackford, Delaware, Fulton, Hancock, Jackson, Knox and Lawrence—each with one death. Allen County had three deaths in March, and Marion County had two.

The summary for the past quarter and the figures for the month of March are shown below:

County	*Total for Quarter*	*March, 1933*	*County*	*Total for Quarter*	*March, 1933*
Allen	4	3	Marion	7	2
Bartholomew	1	1	Monroe	1	0
Blackford	1	1	Parke	1	0
Daviess	2	0	Pike	1	0
Delaware	1	1	Ripley	1	0
Dubois	1	0	Shelby	2	0
Fulton	1	1	Sullivan	2	0
Hancock	1	1	Switzerland	1	0
Harrison	1	0	Tippecanoe	3	0
Howard	1	0	Vigo	1	0
Jackson	1	1	Wayne	1	0
Knox	1	1	Wells	1	0
Lake	1	0	Vanderburgh	1	0
Lawrence	1	1		—	—
				41	13

DISTRICT MEETINGS IN MAY

FIRST DISTRICT

Officers

President—C. D. Ehrman, M. D., Rockport.
Secretary—K. T. Meyer, M. D., Evansville.
Place of Meeting—Princeton.
Date of Meeting—May 18, 1933.

Program

1:00 p. m. Golf Tournament.

6:30 p. m. Banquet.
Symposium: Medical Economics.
Speakers:
J. H. Weinstein, M. D., Terre Haute.
E. E. Padgett, M. D., Indianapolis.
J. H. Hare, M. D., Indianapolis.
Thomas A. Hendricks, Indianapolis.

THIRD DISTRICT

Officers

President—C. E. Boyd, M. D., French Lick.
Secretary—G. R. Dillinger, M. D., French Lick.
Place of Meeting—French Lick Springs Hotel.
Date of Meeting—May 10, 1933.

Program

10:00 a. m. L. H. Allen, M. D., Bedford.
Subject: "Medical Management of Gall Bladder Disease."

10:30 a. m. Frank Walker, M. D., Indianapolis.
Subject: "Pelvic Infections."

11:10 a. m. Carl P. Schoen, M. D., New Albany.
Subject: "Diaphragmatic Hernia."

11:40 a. m. John H. Warvel, M. D., Indianapolis.
Subject: "Diabetes."
1:00 p. m. Luncheon.
Address by Joseph H. Weinstein, M. D., Terre Haute.

FOURTH DISTRICT

Officers

President—G. H. Kamman, M. D., Seymour.
Secretary—H. P. Graessle, M. D., Seymour.
Place of Meeting—Elks' Club, Seymour.
Date of Meeting—May 17, 1933.

Program

9:00 a. m. Golf.
1:00 p. m. Scientific Program.
G. H. Kamman, M. D., Seymour.
Subject: President's Address—"Proper Spirit Among Fellow-Practitioners."
C. L. Williams, M. D., Greensburg.
Subject: "Philosophy in Medicine."
Anna Goss, M. D., Madison.
Subject: "General Practitioner and the Laboratory."
M. C. McKain, M. D., Columbus.
Subject: "Unusual Abdominal Conditions."
W. H. Stemm, M. D., North Vernon.
Subject: "Angina Pectoris."
4:30 p. m. Irvin Abell, Louisville.
Subject: "Tumors of the Breast."
6:30 p. m. Banquet.
Thurman B. Rice, M. D., Indianapolis.
Subject: "An Economical Health Program."

Visiting ladies will be entertained at the Seymour Country Club.

FIFTH DISTRICT

Officers

President—C. S. Carmichael, M. D., Seeleyville.
Secretary—F. E. Sayers, M. D., Terre Haute.
Place of Meeting—Elks' Club, Terre Haute.
Date of Meeting—May 5, 1933.

Program

Symposium on Poliomyelitis.
Speakers:
W. H. Allen, M. D., Louisville.
Virgil E. Simpson, M. D., Louisville.
J. H. Pritchett, M. D., Louisville.
Frank Strickler, M. D., Louisville.

SIXTH DISTRICT

Officers

President—W. R. Phillips, Glenwood.
Secretary—Charles S. Houghland, Milroy.
Place of Meeting—Greenfield.
Date of Meeting—May 25, 1933.

Program

B. G. Kenney, M. D., Shelbyville.
Subject: "Water Metabolism and Kidney Physiology."
George Wiggins, M. D., and L. C. Marshall, M. D., New Castle.
Subject: "The Dehydration Treatment of Eclampsia."
Harry P. Ross, M. D., Richmond.
Subject: "Biography of William Osler and Sir James Mackenzie."
Charles Titus, M. D., Wilkinson.
Subject: "Systemic Effects of Diseased Tonsils."

NINTH DISTRICT

Officers

President—V. L. Turley, M. D., Fowler.
Secretary—Thomas L. Keefe, M. D., Earl Park.
Place of Meeting—Hazelden, Brook, Indiana, the home of George Ade.
Date of Meeting—May 23, 1933.

Program

8:30 a. m. Golf Tournament for Delegates and Officers.
12:30 p. m. Luncheon for Delegates and Officers.
2:00 p. m. Luncheon Bridge for Ladies.
2:00 p. m. Scientific Lectures.
Dr. Rollin T. Woodyatt, Chicago.
Subject: "Emergencies Arising in the Course of Diabetes."
Dr. Vernon C. David, Chicago.
Subject: "The Surgical Significance of Inflammatory Lesions of the Colon."
Dr. J. O. Parramore, Crown Point.
Subject: "Some Practical Phases of Tuberculosis."
Discussed by selected members of the society.
7:00 p. m. Dinner for Members and Guests.
9:00 p. m. Informal Dancing.

ELEVENTH DISTRICT

Officers

President—C. M. Kennedy, M. D., Camden.
Secretary—O. G. Brubaker, M. D., North Manchester.
Place of Meeting—Huntington.
Date of Meeting—May 17, 1933.

Program

2:00 p. m. Business and Scientific Program.
Speakers:
L. G. Zerfas, M. D., Indianapolis.
W. D. Little, M. D., Indianapolis.
O. G. Brubaker, M. D., North Manchester.
Officers of the State Association.

DEATH NOTES

THOMAS C. DODDS, M. D., of Hartford City, died March thirteenth, aged fifty-seven. Dr. Dodds graduated from the Eclectic Medical College, Cincinnati, in 1898.

SAMUEL MASON, M. D., of Pennville, died March sixteenth, aged eighty-eight years. Dr. Mason had not been in active practice for several years. He was a Civil War veteran. He graduated from the Indiana Medical College, Indianapolis, in 1873.

CHARLES H. PERRY, M. D., of Lewis Creek, died March tenth, in Indianapolis, following an illness of several weeks duration. He died on his fifty-eighth birthday. He graduated from the Hospital College of Medicine, Louisville, Kentucky, in 1896.

DR. CLARENCE F. FISHER, aged twenty-six, an interne at St. Elizabeth's Hospital, Lafayette, died in a Lebanon hospital, April seventh. His death resulted from injuries received in an automobile accident the day before.

JOHN A. WHITE, M. D., of Indianapolis, died April tenth, aged forty-five years. Dr. White served as a captain in the medical corps of the U. S. Army during the World War. He was a member of the Indianapolis Medical Society, the Indiana State Medical Association and the American Medical Association.

FRED W. MAYER, M. D., of Indianapolis, died March twenty-ninth, aged forty-nine years. Dr. Mayer had been a Marion County health commissioner for six years. He was a member of the Indianapolis Medical Society, the Indiana State Medical Association, and the American Medical Association. He graduated from the Indiana Medical College (Purdue) in 1907.

LAURA CARTER, M. D., of Shelbyville, died April fourth, aged sixty-six years. She had practiced medicine in Shelbyville since 1904. Dr. Carter was a member of the Shelby County Medical Society, the Indiana State Medical Association, and the American Medical Association. She graduated from the Laura Memorial Woman's College, Cincinnati, in 1902.

JOSIAH J. SCHROCK, M. D., of Greentown, died in a Gary hospital, of pneumonia, March tenth. Dr. Schrock was seventy-seven years of age. He graduated from the medical department of Western Reserve University, Cleveland, in 1887.

GARRETTE VAN SWERINGEN, M. D., of Fort Wayne, died March twenty-eighth, aged fifty years. Dr. Van Sweringen was a member of the Fort Wayne Medical Society, the Indiana State Medical Association, and the American Medical Association. He was a staff member of the Lutheran Hospital in Fort Wayne. Dr. Van Sweringen graduated from the Fort Wayne College of Medicine in 1903, and from the Jefferson Medical College of Philadelphia in 1905.

ELMER L. BOYD, M. D., of Evansville, died March 27, 1933, after an illness of several months. Dr. Boyd was a member of the staff of the Deaconess and of the St. Mary's Hospitals, and was a member of the Vanderburgh County Medical Society, the Indiana State Medical Association and the American Medical Association. He graduated from Rush Medical College, Chicago, in 1924. He was forty-three years old. Dr. Boyd had been engaged in the practice of medicine with his wife, Dr. Stella Boyd, who survives him.

EDWIN H. UNDERWOOD, M. D., of Fort Wayne, died April third, aged sixty-one years. Dr. Underwood served during the World War as a lieutenant in the medical corps. He was a member and had served as president of the Lutheran Hospital staff in Fort Wayne, and was a member of the Fort Wayne Medical Society, the Indiana State Medical Association, and the American Medical Association. He graduated from the General Medical College, Chicago, in 1905.

EMIL BESSER, M. D., of Remington, died April fourteenth, aged sixty-five years. Dr. Besser was ill for two weeks, with pneumonia. He was president of the Jasper county board of commissioners and recently had been re-elected for the second term in that office. Dr. Besser graduated from the Chicago Homeopathic Medical College in 1899, and had practiced medicine in Remington for thirty-seven years. He was a member of the Jasper-Newton County Medical Society, the Indiana State Medical Association and the American Medical Association.

HOOSIER NOTES

DR. D. F. RANDOLPH, of Waldron, celebrated his eightieth birthday March twenty-sixth.

DR. BOYD BURKHARDT, of Tipton, was operated for acute mastoiditis, in Indianapolis, April 17th.

DR. HAROLD BRUBAKER, of Huntington, has been appointed county physician by the Huntington County commissioners.

DR. MAX CUTLER, of Chicago, talked to members of the Wells County Medical Society, at Bluffton, April eighteenth. His subject was "Cancer."

DR. F. C. REEL, of Holton, has assumed his duties as physician for the Feeble-Minded Colony at Butlerville.

DR. OSCAR D. LUDWIG, of Indianapolis, has been appointed to fill the unexpired term of the late Dr. Fred W. Mayer as county health officer.

MISS MARGARET KLUGER and Dr. Emmett B. Lamb, of Indianapolis, were married April fifth, in Indianapolis.

DR. DONALD W. SCHAFER, of Fort Wayne, has announced removal of his offices to the Cal-Wayne Building in that city.

DR. J. E. GUDGEL, of Cynthiana, celebrated the fiftieth anniversary of his entrance into the practice of medicine in Posey County, April second.

DR. GOETHE LINK, of Indianapolis, was the principal speaker at the March thirtieth meeting of the Tipton County Medical Society.

DR. AND MRS. F. E. RADCLIFFE, of Bourbon, have returned to their home after spending several months in Florida.

MEMBERS of the Indiana Credentials Committee of the American College of Surgeons met in Indianapolis, April eighth.

DR. AND MRS. M. G. YOCUM, of Mentone, entertained the members of the Kosciusko County Medical Society, April 11th.

THE Carroll County Medical Society met at Delphi, April fourteenth, to hear Dr. J. O. Ritchey, of Indianapolis, present a paper on "Neuritis."

DR. J. B. MAXWELL has returned to Logansport and has opened an office for the general practice of medicine. Dr. Maxwell recently resigned his position at Muscatatuck Colony, Butlerville.

IN a lecture, open to the public, Dr. John S. Boggess, of Louisville, explained operations of the United States Public Health Service, at the Muncie Academy of Medicine, April fourth.

FIFTY physicians attended the meeting of the Northeastern Indiana Academy of Medicine, at Kendallville, March thirtieth. Dr. Norris W. Gillette, of Toledo, discussed "Goitre."

DR. M. R. VANNUYS, superintendent of the State Village for Epileptics at Newcastle, was the speaker at the Rotary Club luncheon, March twenty-eighth, at Anderson.

DR. G. F. HOLLAND, of Bloomington, gave an interesting talk on "The Changes of Medicine and the Practitioners Since 1800" before Bloomington Rotarians, March twenty-second.

THIRTY-ONE members and six visitors attended the meeting of the Wayne-Union County Medical Society at the Richmond-Leland Hotel, Richmond, March twenty-third.

DR. FRANK W. CREGOR, of Indianapolis, addressed the members of the Bartholomew County Medical Society at Columbus, March fifteenth; his subject was "Congenital Syphilis."

MEMBERS of the Cass County Medical Society met at Logansport, March seventeenth, to hear Dr. E. F. Kiser, of Indianapolis, talk on "The Senile Heart." Attendance numbered thirty.

"TUMORS OF THE GENITO-URINARY TRACT" was the subject of a paper presented by Dr. L. K. Phipps, before the Randolph County Medical Society, at Winchester, March thirteenth.

MEMBERS of the Hendricks County Medical Society met at Danville, March seventeenth. Dr. G. S. Bond, of Indianapolis, was the speaker, his subject being "Diseases of the Heart."

MEMBERS of the Whitley County Medical Society enjoyed a chicken dinner at the Hicks Tavern, South Whitley, March fourteenth. Dr. E. V. Nolt, of Columbia City, presented a paper.

A DINNER meeting was held in the Graham Hotel, Bloomington, by members of the Monroe County Medical Society, March fourteenth. Moving pictures formed a part of the program.

DR. WALLACE S. DUNCAN, of Cleveland, spoke on "The Management of Arthritis" before the members of the Muncie Academy of Medicine, at the Hotel Roberts, March fourteenth.

THE regular meeting of the Rush County Medical Society was held April third at Rushville. Dr. Karl Koons, of Indianapolis, was the principal speaker.

DR. R. E. MCINDOO was the principal speaker at the April meeting of the Howard County Medical Society, in Kokomo, April seventh. His subject was "Hodgkin's Disease."

DR. M. F. STEELE, of Fort Wayne, former superintendent of the Methodist Hospital in that city, has gone to Columbus, Ohio, to take over similar duties at Grant Hospital in Columbus.

DR. B. S. CORNELL, of Fort Wayne, addressed the members of the Wells County Medical Society at Bluffton, March 21. His subject was "Angina Pectoris."

THE Gibson County Medical Society met at the Methodist Hospital and Roxy Theater, Princeton, April 12th. Five reels of motion pictures entitled "Cancer of the Skin," were shown.

DR. C. A. TINDALL, of Shelbyville, was the principal speaker before the regular monthly meeting of the Shelby County Medical Society at Shelbyville, April twelfth.

DR. B. R. KIRKLIN, of the Mayo Clinic, formerly of Muncie, addressed the Muncie Academy of Medicine, April eleventh. Dr. Kirklin presented an illustrated lecture dealing with progress in the field of x-ray.

DRS. A. B. Graham and J. W. Ricketts, both of Indianapolis, presented a discussion of "Colon and Rectal Diseases" at the meeting of the Fort Wayne Medical Society, April eighteenth.

THE eighty-fourth annual session of the American Medical Association will be held in Milwaukee, Wisconsin, from Monday, June twelfth, to Friday, June sixteenth.

MEMBERS of the Porter County Medical Society met at the Lempke Hotel, March twenty-eighth, for a dinner meeting. "Treatment of Common Colds in Children" was the subject of a paper presented by Dr. J. A. Corcoran, of Chicago.

DR. HERMAN C. GROMAN, of Hammond, and Miss Jeannette Edwards, of Waterloo, Iowa, were married March nineteenth, in Chicago. Dr. and Mrs. Groman have only recently returned from a trip to Florida.

The Committee on Postgraduate Study, in arranging the meeting of this year, has decided to give the program at Richmond, Indiana, on Thursday, June 1st.

The Wayne County Medical Society has entered enthusiastically into arrangements for this meeting. The committee deemed it wise to limit the course to nine hours, but the quality of the instruction will be of high character. Subjects of practical interest will be discussed by teachers of known ability as instructors, so that those in attendance will be assured a profitable day. All speakers have been asked to present their subjects in a manner of greatest pedagogical value.

The preliminary program includes, among other speakers, Dr. A. C. Ivy, Professor of Physiology, Northwestern University Medical College; Dr. Thomas Fitz-Hugh, Philadelphia, and Dr. W. H. Cole, Barnes Hospital, St. Louis. The completed program will be sent to the secretaries of County Medical Societies, and to any interested physician requesting it.

Murray N. Hadley, M. D., Chairman,
Postgraduate Committee.

A meeting will be held at 5 P. M., Thursday, June 1st, immediately following the afternoon session of the Postgraduate Clinic, in Richmond, for the purpose of announcing the plans of the Indiana State Board of Health and the medical profession for child health work in the state.

The child health work of Indiana is now in the hands of a committee and the co-operation of all the doctors of the state is desired.

Dr. M. D. Gwin, of Rensselaer, was host to members of the Jasper-Newton County Medical Society, March thirty-first. Dr. E. S. Jones, of Hammond, spoke on "New Treatment of Peritonitis and Peritonitis Appendicitis."

The regular monthly meeting of the Elkhart County Medical Society was held April sixth, at the Hotel Elkhart. This was a dinner meeting. Dr. Joseph L. Miller, of Chicago, presented a paper on "Clinical Diagnosis."

The Vanderburgh County Medical Society held a meeting in the McCurdy Hotel, Evansville, March fourteenth. L. P. Dean, M. D., of St. Louis, spoke on "Relation of Sinus Infection to Pulmonary Tuberculosis."

Dr. Frank Walker, of Indianapolis, addressed members of the Huntington County Medical Society, April fourth, at the Hotel Lafontaine, Huntington. Dr. Walker's subject was "Pelvic Infection."

Dr. Louis H. Segar, of Indianapolis, was the principal speaker before the members of the Lawrence County Medical Society, April fifth. This was a luncheon meeting, held in the Greystone Hotel, Bedford.

Flint, Mich., has been selected as the meeting place for the Northern Tri-State Medical Society in 1934. Dr. G. O. Larson, of LaPorte, was elected president of the organization at its sixtieth annual meeting held in April.

Dr. Herman L. Kretschmer, of Chicago, presented an illustrated lecture before the LaPorte County Medical Society, March sixteenth, at Michigan City. Dr. Kretschmer's subject was "Modern Treatment of Bladder Neck Obstructions."

The third issue of "The Hebrew Physician" (Harofeh Ho'Ivri), the only Hebrew medical journal published outside of Palestine, is available. Any physicians who are interested in this journal may communicate with The Hebrew Physician, 983 Park Avenue, New York, N. Y.

Dr. Morris Fishbein, editor of *The Journal* of the A. M. A., addressed members and guests of the Indianapolis Medical Society at the Athenaeum, April fourth. His subject was "State Medicine and Contract Practice." This was an excellent meeting with many out-of-town guests present.

Members of the Wayne-Union County Medical Society met at the Richmond-Leland Hotel, April thirteenth, for a dinner meeting. An obstetrical seminar comprised the program. Drs. Thad Gillespie and William Gillespie, of the University of Cincinnati, were the principal discussants.

The March meeting of the Madison County Medical Society was held at Anderson, in the Anderson Hotel, March twentieth. Dr. Paul A. O'Leary, of the Mayo Clinic, was the guest speaker. He chose for his subject "Therapeutic Problems in Syphilis."

The Mid-western Section of the American Congress of Physical Therapy will meet Monday, May 15th, in the Hotel Jefferson, at Peoria, Ill. The twelfth annual meeting of the Congress will be held at the Palmer House in Chicago, September 11th to 15th, 1933.

Members of the Hamilton County Medical Society met at Sheridan for a dinner meeting, April 11th. Dr. R. A. Solomon, of Indianapolis, presented a paper on "Therapeutics of Cardiovascular-renal Disease." Attendance numbered twenty-four.

Dr. Herbert F. Thurston, of Indianapolis, presented a thirty minute talking picture demonstration of "Experimental Surgery of Blood Vessels," and Dr. O. E. Carter, of Indianapolis, talked about "Peripheral Vascular Disease" at the April 18th meeting of the Indianapolis Medical Society.

The April twentieth meeting of the LaPorte County Medical Society was held at the Rumley Hotel, Laporte, with Dr. R. A. Flack, of Lafayette, as the speaker. Dr. Flack's subject was "Early Diagnosis of Goiter."

The University of Nebraska College of Medicine will conduct a postgraduate course from May 15th to May 20th, in Omaha. The course is offered under the auspices of the Department of Medicine, Neuro-psychiatry and Dermatology. Fee for the course is ten dollars.

EDWARD L. CORNELL, M. D., of Chicago, presented an address and moving pictures concerning obstetrics, before members of the Tippecanoe County Medical Society, Lafayette, April 13th. The afternoon clinic had an attendance of sixty, and the moving picture exhibition in the evening attracted ninety physicians.

THE Fountain-Warren County Medical Society met at Kingman, April sixth. Speakers were Drs. J. H. Weinstein, of Terre Haute, F. S. Crockett, of Lafayette; O. O. Alexander, Terre Haute; A. F. Weyerbacher, Indianapolis; and Mr. Thomas A. Hendricks, Indianapolis. Thirty-seven members attended.

MEMBERS of the Sullivan County Medical Society held their regular monthly meeting at the Mary Sherman Hospital, Sullivan, April fifth. A per was presented on "Post-Operative Atelectasis" by Dr. J. T. Oliphant, and a "A Case of Fever of Unknown Origin" was reported by Dr. J. J. Parker.

SIR HENRY DALE, director of the National Institute for Medical Research of England, and one of the world's leading authorities on pharmacology, was the principal speaker at the dedication of the new Merck Research Laboratory, at Rahway, New Jersey, April twenty-fifth. The laboratory, just completed at a cost of $200,000, is considered one of the most modern of its kind in the world.

DR. ALFRED ELLISON, whose home is in South Bend, has been studying in the graduate school of medicine of the University of Pennsylvania for the past several years, and has received the degree of master of medical science for graduate work in surgery. He will return to practice in South Bend this summer.

MEMBERS of the Indianapolis Woman's Auxiliary are planning beautification of the grounds of the City Hospital in Indianapolis as a memorial to Indianapolis physicians who have given and are giving their services to the needy. The plans include dedication of a boulder inscribed to the doctors, and the opening of an elm-lined memorial walk from the City Hospital to the James Whitcomb Riley Hospital for Children.

THE mid-western section of the American Congress of Physical Therapy will conduct a one day scientific program on Monday, May fifteenth, at the Hotel Jefferson, Peoria, Illinois, immediately preceding the annual meeting of the Illinois State Medical Society which convenes on May sixteenth. Members of the medical profession are cordially invited. There will be no registration fee.

THE Lake County Medical Society met April thirteenth at the Mercy Hospital in Gary, and April twenty-seventh, at St. Margaret's Hospital in Hammond. Dr. Frank C. Mann, of Rochester, talked about "The Pathological Physiology of the Liver" at the first meeting, and Dr. Joseph Colt Bloodgood, of Baltimore, was the guest of honor at the second meeting. Dr. Bloodgood conducted a cancer clinic in the afternoon and presented a paper on that subject in the evening.

MEMBERS of the St. Joseph County Medical Society met at South Bend, March 29th. Dinner was served at 6:30 at the Oliver Hotel. Dr. J. A. Myers, professor of preventive medicine, University of Minnesota, spoke on "Childhood Tuberculosis." Seventy attended the dinner; two hundred attended the evening meeting. This was a Darden Memorial meeting, sponsored by the Tuberculosis League and the St. Joseph County Medical Society in honor of the late Dr. St. Clair Darden.

DR. WILLIAM GILLESPIE, of Cincinnati, addressed the April 13th meeting of the Wayne-Union County Medical Society at Richmond. He discussed the pathologic causes and treatment of eclampsia and rectal anesthesia. The report of the society's committee, which met with the township trustee, was presented; the trustee will allow the patient to select a physician and pay 50 per cent of the regular fee to all physicians in the township who care to accept. Twenty-eight members and four visitors attended the meeting.

THE seventy-fifth anniversary of the Indiana State Dental Association will be celebrated with a dinner at the Indianapolis Athletic Club on Tuesday, May 16th, at 6:30 p. m. Dr. Morris Fishbein will speak on "Opinions and Superstitions on Health." A most cordial invitation is extended to all members of the Indiana State Medical Association, their ladies and friends. Reservations may be made up to noon Tuesday through the office of the secretary of your association, Thomas A. Hendricks, 1021 Hume Mansur Bldg., Indianapolis. $1.10 per cover. Dress informal.

THE Metropolitan Life Insurance Company is prepared to lend to responsible organizations motion picture films for use in educational work. Available at the present time are the following subjects: Working for Dear Life; The Conquest of Diphtheria; Too Many Pounds; Man Against

Microbes; How to Live Long; and Lives of Pasteur, Trudeau, Reed, Nightingale and Koch. Literature concerning the themes of the films will be furnished if desired. Requests for information of films should be addressed to the Metropolitan Life Insurance Company, Welfare Division, 1 Madison Avenue, New York, N. Y.

THE National Society for the Prevention of Blindness announces that to prepare teachers and supervisors for the work of "sight saving" classes, such as are now successfully established in 119 communities throughout the United States, training courses will be offered during the summer of 1933 at the following places: Western Reserve University, Cleveland, Ohio, June 19 to July 29; University College, University of Chicago, Chicago, Illinois, June 26 to August 1; Teachers College, Columbia University, New York City, July 10 to August 18. Information concerning these courses may be secured from the respective universities or from the National Society for the Prevention of Blindness, 450 Seventh Avenue, New York City.

RULES have been adopted by the National Board of Medical Examiners, in harmony with regulations of the Federation of Medical Boards of the United States, concerning acceptance of students trained in European medical schools. Under the new requirements, a candidate for the board's diploma must present evidence of pre-medical education equivalent to the requirements of the Association of American Medical Colleges, and the Council on Medical Education and Hospitals of the American Medical Association; he must have graduated from a four-year medical course in Europe and must have obtained a license to practice medicine in the country in which the medical school from which he graduated is located.

THE annual meeting of the Delaware-Blackford Woman's Auxiliary was held March twenty-first, at the home of Mrs. R. H. Beeson. A pot-luck dinner was served, after which reports were given, including a resume of the work done by the Auxiliary during the past year. The second and fourth Tuesday afternoons of each month are devoted to hospital sewing. Election of officers resulted as follows: Mrs. C. M. Mix, re-elected president; Mrs. R. E. Cole, vice-president; Mrs. C. G. Rea, secretary, and Mrs. W. J. Molloy, treasurer.

DR. WILLIAM F. KING, recent secretary of the Indiana State Board of Health, is general chairman of the committee in charge of the meeting of the American Public Health Association which will be held in Indianapolis the week of October ninth to thirteenth. The Association met in Indianapolis the last time in 1900, at which time Dr. Walter Reed gave his first official report of the Havana yellow fever experiment. Dr. Reed's report did not attract much attention at that time, but was one of the outstanding events in the field of preventive medicine, and was so recognized later. This year's Indianapolis session will have one general meeting devoted to the Havana experiment, and as many of the survivors as can be reached will be brought to Indianapolis for the meeting. It was largely through Dr. King's efforts that Indianapolis was decided upon as the meeting place for the Association this year.

IN addition to the articles already enumerated the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

Don Baxter Intravenous Products Corporation
- Sterile 2½% Dextrose Solution in Vacoliter Container
- Sterile 7½% Dextrose Solution in Vacoliter Container
- Sterile 20% Dextrose Solution in Vacoliter Container
- Sterile 25% Dextrose Solution in Vacoliter Container

Bilhuber-Knoll Corporation
- Metrazol Solution 10 per cent

Diarsenol Co., Inc.
- Neodiarsenol, 1.5 Gm. Ampoules
- Neodiarsenol, 3 Gm. Ampoules
- Neodiarsenol, 4.5 Gm. Ampoules

Hixson Laboratories, Inc.
- Diphtheria Toxin-Antitoxin Mixture 0.1 L+
- Diphtheria Toxin-Antitoxin Mixture 0.1 L+ (Sheep)
- Diphtheria Toxoid
 - Diphtheria Toxoid two 1 cc. vial package
 - Diphtheria Toxoid one 10 cc. vial package
 - Diphtheria Toxoid one 30 cc. vial package
 - Diphtheria Toxoid twenty 1 cc. vial package

Lederle Laboratories, Inc.
- Plantain Pollen Antigen-Lederle

Merck & Co., Inc.
- Chlorbutanol (Hydrous)-Merck
- Chlorbutanol (Anhydrous)-Merck
- Neocinchophen-Merck

The following products have been included in the list of articles and brands accepted by the Council but not described in N. N. R. (New and Nonofficial Remedies, 1933, p. 437):

Merck & Co., Inc.
- Bismuth Betanaphthol-Merck
- Bismuth Subsalicylate-Merck
- Phenobarbital-Merck
- Procaine Crystals-Merck
- Thymol Iodide-Merck

WOMAN'S AUXILIARY

The members of the Woman's Auxiliary to the Medical Society of Wisconsin and to the Medical Society of Milwaukee County extends to the wives of members of the American Medical Association a most cordial invitation to be their guests during the coming meeting of the American Medical Association to be held in Milwaukee the week of June 11, 1933.

The committee has spared neither time nor expense to arrange a good time for us. An interesting program will be offered. Entertainment is being planned, and every effort is being made to insure a pleasant and comfortable stay in Milwaukee.

Let us see that Indiana is well represented at this meeting.

Auxiliaries and Auxiliary members all over the state have responded most beautifully to the suggestions of "Further Use for Hygeia." The hospitals and schools are grateful for these magazines, and many are benefited by and through them. When you have finished with your copy, please pass it on.

Has your Auxiliary enjoyed a "covered dish" dinner? For particulars, ask the members of the Lawrence County Auxiliary, for they have found these dinners to be everything they wished, and more—and it is such a nice way to begin a meeting.

At a dinner meeting of the Ripley County Auxiliary, Mrs. George A. Hendon, of Louisville, Kentucky, gave a most interesting account of the life of Jane Todd Crawford, pioneer heroine of surgery.

Election of officers for the Vigo County Woman's Auxiliary was held at the April meeting, at the home of Mrs. J. C. Schaffer, with the following results: president, Mrs. E. T. Zaring; first vice-president, Mrs. E. L. Mattox; second vice-president, Mrs. J. R. Loving; treasurer, Mrs. Byron Hutchings; and secretary, Mrs. Ivan Gilbert.

MRS. R. L. COMPTON,
Recording Secretary.

SOCIETIES AND INSTITUTIONS

INDIANA STATE MEDICAL ASSOCIATION EXECUTIVE COMMITTEE

April 4, 1933.

Meeting called to order at 4:30 p. m.

Roll call showed the following present: W. H. Kennedy, M. D., chairman; H. H. Wheeler, M. D.; J. H. Weinstein, M. D.; O. O. Alexander, M. D.; E. E. Padgett, M. D.; A. F. Weyerbacher, M. D., and T. A. Hendricks, executive secretary.

The bills for March were approved for payment.

The monthly statements of Receipts and Expenditures in March and the Report of the Budget for March for the headquarters office and THE JOURNAL were presented.

MEMBERSHIP REPORT

Number of members on March 31, 1933	2230
Number of members on March 31, 1932	2501
Loss over last year	271
Number of members on April 4, 1933	2231
Number of members on April 4, 1932	2507
Loss over last year	276
Number of members on Dec. 31, 1932	2722

CANCELLATION OF BANK NOTE

As a result of the local banking moratorium, preceding the bank holiday, the funds of the Association were tied up for a period of time in the Indiana National Bank. Through the courtesy of the bank the Indiana State Medical Association was allowed, by signing a note, to release $1,000.00 of its funds. At the end of the restricted period the note was cancelled, the interest payment of $1.67 being refunded. Instructions were given that a letter be written to the officers of the Indiana National Bank thanking them for their courtesy in this matter.

1933 CONVENTION

(1) Letter received from George Dillinger, M. D., general chairman of the convention arrangements, stating that Mr. Fawcett, manager of the French Lick Springs Hotel, had written him saying that the hotel "will be glad to take care of the visiting speakers not to exceed four with complimentary rooms."

(2) The secretary was instructed to sign the contract with the French Lick Springs Hotel.

ADMISSION OF PATIENTS TO RILEY HOSPITAL

Letter received from Dr. D. O. Kearby who sometime ago had made a suggestion in regard to this, brought to the attention of the Committee. This letter stated that Dr. Kearby had had several conferences with Dr. E. T. Thompson, administrator of the University Hospitals, relative to this subject, and that the following plan was thought to be most advisable:

"That all county secretaries be instructed that the administrator of the Hospitals will provide the name, diagnosis and referring doctor, upon request, of all cases admitted from that particular county. My original idea that these be furnished by the hospitals to the county secretaries, as a matter of routine and form, is in my opinion ill advised, would necessitate a tremendous amount of work in the university and an expense not justified. Some counties probably would not be interested at all and the work and expense would be lost. The scheme as now recommended above will require of any county secretary that is interested, only the time and expense of a request to the University Hospitals administrator where the information will be given."

In addition to this the secretary reported that he was informed by Dr. Kearby that Dr. Thompson was willing and

ready to appear before any county medical society so desiring and answer any questions in regard to the Riley and the Long Hospitals. Recently a meeting along this line was held in Cass county, the judge, trustees, local officials, and members of the county medical society being present. Dr. Thompson reported that this meeting was very much worthwhile and that he would be available to go to any county which might hold similar meetings. The Committee instructed the executive secretary to have Dr. Thompson write a letter concerning this which would appear along with Dr. Kearby's letter in THE JOURNAL, and that a letter be written to the secretaries of the various county medical societies telling them of the plan which had been suggested. These letters and this article were to come through Dr. W. P. Garshwiler, chairman of the Public Relations Committee, to which this matter had been referred.

LETTERS FROM LABORATORY MEN

Letters from B. W. Rhamy, M. D., of the Fort Wayne Medical Laboratory, and A. S. Giordano, M. D., South Bend, brought to the attention of the Executive Committee. These letters charge that "there is strong probability that the state laboratory is not living up to its agreement with the laboratory men and the House of Delegates to make the physicians fill out the new Wasserman cards in full, and to refuse to do any Wassermans except for proven indigents."

INDIANA SECTION OF AMERICAN PEDIATRICS SOCIETY

Dr. O. N. Torian appeared before the Committee and asked that the State Association cooperate with this new society in its plans for education in pediatrics of the puhlic and the profession, the public by distribution of literature, and the profession by postgraduate courses. The Executive Committee authorized the president to appoint a special committee to meet with a committee from the American Pediatric Society and formulate plans and report to the next meeting of the Executive Committee.

CASE AGAINST W. M. ROWLAND

Correspondence in regard to the Rowland case was brought to the attention of the Committee. It was reported that Albert Stump was assisting the Fayette-Franklin Medical Society in this case.

PROSECUTION OF CANCER QUACK AT BROOKVILLE

Letter received from Charles R. Baker, the prosecuting attorney at Brookville, Indiana, stating that a man was attempting to practice medicine in Franklin county "who has no legal qualification, in any way, shape or form, to so practice. His specialty is cancer cure." Copies of Mr. Baker's letter have been sent to the State Board of Medical Registration and Examination and to the officers of the Fayette-Franklin Medical Society.

CONTRACT PRACTICE

Letter was received from Dr. H. C. Ragsdale, councilor of the Third District, asking for information in regard to contract practice. The matter was referred to Dr. Olin West, secretary of the American Medical Association, who wrote in part, "It is specifically stated in that section of The Principles of Medical Ethics that it is unprofessional for a physician to dispose of his services under conditions that make it impossible to render adequate service to his patient or that interfere with reasonable competition among the physicians of the community. When physicians resort to distinct underbidding for the purpose of securing a contract, it would seem that their conduct could hardly be considered to be in keeping with the provisions of the Principles of Medical Ethics.

"The Judicial Council has recently decided an appeal involving a contract held by a group of splendid physicians. Under the decision of the Council, the contract was declared by the Council to be unethical because the contract was of a nature that was opposed to the public welfare."

MEDICINAL WHISKY

Resolution passed by the Fort Wayne Medical Society asking that the Indiana State Medical Association "procure a decision from the Indiana supreme court on the recent opinion of the Indiana attorney-general that practioners of medicine may not have the 12 pints of whisky allowed by the federal government." Notation in the April number of THE JOURNAL that it is reported on good authority that the excise director of Indiana is to issue a ruling that physicians may have twelve pints of whisky for emergency medical purposes, brought to the attention of the Committee.

WHAT IS A CLINIC?

Question brought before Committee as to exactly what constitutes a clinic. The suggestion was made that Dr. O. O. Alexander prepare material on this subject which could be submitted to the editor of THE JOURNAL.

PAMPHLET ON MEDICAL LEGAI QUESTIONS

Letter received from Walter L. Portteus, M. D., Franklin, suggesting that pamphlet be printed covering in simple language such medical legal questions as to a physician's relation to court cases, compensation cases, etc. The Committee felt that such a pamphlet would be unnecessary as these subjects of timely interest are covered each month in the medical legal department of THE JOURNAL. Any specific questions which anyone may have will be answered in this column. The secretary was instructed to write Dr. Portteus, outlining these facts.

ANNUAL MEETING OF AMERICAN PUBLIC HEALTH ASSOCIATION

Dr. William F. King, secretary of the State Board of Health, requests that the executive secretary of the State Medical Association, act as chairman of the Publicity Committee for this meeting. The Executive Committee thought that the secretary should help out in this matter.

THE JOURNAL

Picture of Dr. Bulson which was ordered by Committee at March meeting received. It is to be placed in THE JOURNAL room at the headquarters office.

The Committee went on record against accepting advertising on basis of returns from advertising; that is, any advertisement that is taken shall be paid for at regular space rates and not upon a commission basis.

Questionnaire on cigarette advertising showed the Editorial Board and the Executive Committee overwhelmingly in favor of accepting properly worded cigarette advertisements. Any advertising accepted by THE JOURNAL must be approved by the American Medical Association.

The Committee approved the idea that certain ethical drug houses might be asked to take cards in THE JOURNAL on a page devoted to such cards.

There being no further business, the meeting was adjourned.

INDIANA STATE MEDICAL ASSOCIATION
BUREAU OF PUBLICITY

January 20, 1933.

Meeting called to order at 3:00 p. m.

Present: William N. Wishard, M. D., chairman; J. H. Stygall, M. D.; E. D. Clark, M. D., and T. A. Hendricks, executive secretary.

Release for publication in Saturday afternoon papers, January 28, "Business Lectures for Medical Students," read and approved.

Radio release, Saturday, January 14—"Smog Sickness."

Report on medical meeting:

Jan. 5—Clinton County Medical Society, Frankfort, Ind. "Medical Economics and Group Practice."

Request for speaker:

Jan. 17—Delaware-Blackford Medical Society, Muncie, Ind. Speakers obtained to talk on "Medical Economics," etc.

Final report of the Commission on Medical Education received and was assigned to one member for review.

Letter received in regard to meeting of Annual Congress on

Medical Education, Licensure and Hospitals, to be held in Chicago, February 13 and 14. The delegate was to take with him a letter of suggestions from the Bureau concerning the attitude of the Bureau toward contract practice.

Program of regional meeting for public health workers held at Kendallville, Indiana, presented to the Bureau by the Director of the Division of Public Health Nursing of the Indiana State Board of Health.

The following report of the Better Business Bureau on the Midland Finance Company of Kansas City, Missouri, which operated in Indiana, was brought to the attention of the Bureau:

"The Indianapolis Bureau has received complaints from business men in Indianapolis to the effect that the contract of this company, which operates a collection agency, has been misrepresented to them by the salespeople. Similar complaints have been received from numerous cities throughout the country and we would urge those that may be approached by these salespeople to get the report of the Better Business Bureau before purchasing. The company offers a guarantee contract whereby they assure the business man that a certain amount of money will be collected or they will pay him a certain amount of cash."

March 16, 1933.

Meeting called to order at 3:30 p. m.

Present: William N. Wishard, M. D., chairman; J. H. Stygall, M. D.; E. D. Clark, M. D., and T. A. Hendricks, executive secretary.

Dental release, "Teeth and Taxes," published March 11, 1933.

Radio releases:

Saturday, January 21—"Carbon Monoxide Gas."
Saturday, January 28—"Basketball and Physical Examinations."
Saturday, February 4—"Home Safety."
Saturday, February 11—"Neuralgia."
Saturday, February 18—"Superstitions About Health."
Saturday, February 25—"Exercise."
Saturday, March 4—"Mumps."
Saturday, March 11—"Sport for Health's Sake."

Reports on medical meetings:

January 12—Hancock County Medical Society, Greenfield, Ind. "Medical Economics."
January 17—Delaware-Blackford Medical Society, Muncie, Ind. "Medical Economics."
January 19—Montgomery County Medical Society, Crawfordsville, Ind. "Medical Economics."
February 22—Hamilton County Medical Society, Noblesville, Ind. Dentists invited. "Medical Economics."

Medical meetings scheduled:

March 17—Owen County Medical Society, Spencer, Ind. Dinner meeting. "Medical Economics."
March 23—Wayne-Union County Medical Society, Richmond, Ind. Dinner meeting. "Medical Economics."
March 28—Grant County Medical Society, Marion, Ind. "Medical Economics."
April 6—Fountain-Warren Medical Society, Kingman, Ind. Dinner meeting. "Medical Economics."
April 14—Floyd County Medical Society, New Albany, Ind. 3:30 p. m., Public Library. "Medical Economics."
May 3—Bartholomew County Medical Society, Columbus, Ind. "Medical Economics."
May 10—Third District Medical Society, French Lick Springs Hotel, French Lick, Ind. 10:00 a. m.
Date not set—Marshall County Medical Society, Plymouth, Ind. "Economic Problems."

Many requests received for pamphlet prepared by the Bureau entitled, "Information Regarding the Prevention of Contagious Diseases."

There being no further business the meeting was adjourned.

March 24, 1933.

Meeting called to order at 3:30 p. m.

Present: William N. Wishard, M. D., chairman; J. H. Stygall, M. D.; E. D. Clark, M. D., and T. A. Hendricks, executive secretary.

Release for publication Saturday, April 8, dental release, "Dental Research in Relation to the Child."

Release for publication in Saturday papers, April 15, "Mumps," read and approved.

Radio release, Saturday, March 18, "Hot Cereal and Milk."

Final approval given to the report of the representatives of the Bureau to the Annual Congress on Medical Education and licensure which was held in Chicago on February 13 and 14. In connection with the subject of medical education the Bureau at a formal meeting had prepared the following official statement which its representative placed before the Congress:

"It is the view of the Bureau of Publicity of the Indiana State Medical Association that the pre-medical requirements for licensees should be more thorough. There are more applicants for licenses than are required to supply the public need. We believe that a basis of preparation for the study of medicine is best secured by a thorough cultural training and this will tend helpfully to improve the personnel of the medical profession and to discourage those unwilling to take proper pre-medical training."

The Bureau suggests that this report be published in THE JOURNAL.

Attention of the Bureau was called to the clipping from "Time" telling of the work that had been done in the Indianapolis City Hospital with sodium amytal as an antidote for strychnine poisoning.

Correspondence received from the director of the Division of Public Health Nursing of the Indiana State Board of Health referred to the editor of THE JOURNAL of the State Association.

Letter received in regard to the one hundredth anniversary of the profession in Wabash County.

Letter received from the secretary of the State Board of Health in regard to the appropriation of $1,000,000 at the recent session of the legislature for emergency relief work throughout the state.

There being no further business the meeting was adjourned.

INDIANA STATE BOARD OF HEALTH

DIVISION OF COMMUNICABLE DISEASES

MONTHLY REPORT, MARCH, 1933

Morbidity reports from health officers, physicians and hospitals of the State show 2,934 cases of diseases during the current month. There were 2,487 cases reported the previous month, and 3,504 cases during the corresponding month of the preceding year. Every county in the State reported either negative or positive. Reports were sent in from all cities having a population of 5,000 or over, except Vincennes, Clinton and Linton. A total of 1,034 negative cards were received.

A summary of diseases from the urban and rural population throughout the State is given below:

Diseases	*Total*	*Urban*	*Rural*
Tuberculosis	232	130	102
Chicken Pox	673	573	100
Measles	389	332	57
Scarlet Fever	695	368	327
Small Pox	9	4	5
Typhoid Fever	7	2	5
Whooping Cough	135	89	46
Diphtheria	122	68	54
Influenza	334	16	318
Pneumonia	40	5	35
Mumps	266	255	11
Poliomyelitis	1	1	0
Meningococcus Meningitis	24	22	2
Trachoma	1	1	0
Vincent's Angina	4	2	2
Ophthalmia Neonatorum	1	1	0
Grand Total	2,934	1,869	1,065

A slight increase is noted in the number of diseases reported, as compared with the previous month.

DIPHTHERIA. A favorable decline is shown in diphtheria. During the current month 122 cases were reported; 160 cases the previous month; and 169 cases during the corresponding month of the preceding year. The estimated expectancy was 129 cases. The estimated expectancy is based on the experience of the last seven years.

SCARLET FEVER. The reported incidence of scarlet fever, 695 cases, shows a twenty per cent increase, as compared with the previous month, when 554 cases were reported. In March of last year there were 594 cases. The average number of cases in the month of March for the last five years is 725.

MEASLES. This is measles time. 389 cases were reported for the current month; 73 cases during the previous month; and 241 cases the same month last year. The estimated expectancy for March for the last seven years is 2,120 cases.

TYPHOID FEVER. A slight decrease is noted in typhoid fever. Thirteen cases were reported last month and 11 cases the corresponding month of the previous year. The number of cases (7), for the current month indicates the decline of this disease.

SMALLPOX. The prevalent incidence of smallpox (9 cases), is the least number of cases reported for the month of March in the history of the Division. The estimated expectancy was 490 cases. The estimated expectancy is based on the experience of the last seven years.

INFLUENZA. The reported incidence (334 cases) of influenza indicates that the epidemic is slowly receding. 414 cases were reported during the previous month; there were 2,431 cases in the month of January of this year; and 5,118 cases reported in December of last year.

MENINGOCOCCUS MENINGITIS. A marked increase is noted in meningococcus meningitis. There were seven cases reported the previous month; twenty-one of the current cases were reported from Marion County, and one case each from Lake, Monroe and Montgomery counties.

H. W. MCKANE, M. D.

CLINTON COUNTY MEDICAL SOCIETY

The Clinton County Medical Society met in regular session at the Coulter Hotel, Frankfort, Thursday evening, April 6th, at 5:30 p. m., with Dr. John S. Ketcham, president, presiding.

Upon roll call the following members were noted as present: Drs. H. R. Royster, C. A. Burroughs, William C. Mount, William C. Mount, Jr., R. A. Hedgecock, S. B. Sims, Chas. A. Compton, J. S. Ketcham, F. A. Beardsley, M. F. Boulden, C. A. Robison, and I. E. Carlyle.

Dr. Roy V. Myers, of Indianapolis, was the guest of the society.

After the usual routine of business was dispensed with, the meeting was turned over to Dr. Myers who presented a paper on "Pelvic Inflammation," discussing the diagnosis and conservative treatment of the same. Dr. Myers laid particular stress on the medical side of this treatment, and while he told us of the surgical procedures he also elaborated very extensively on the medical care of these patients.

No further business appearing the meeting adjourned.

IVAN E. CARLYLE, M. D., *Secretary.*

HANCOCK COUNTY MEDICAL SOCIETY

The Hancock County Medical Society held its regular monthly meeting at the Bowman Hotel, Greenfield, April 10, 1933.

Meeting was in charge of Dr. James R. Woods.

"The Magic Hand," by Herbert Collins, was well received. Mr. Collins is a pre-medical student from Hancock County.

"Sex Hormonology" was the subject of a splendid paper presented by Dr. Carl Habich, of Indianapolis. He discussed the value of hormones therapeutically and the methods of determining pregnancy.

Eleven members and two guests were present.

The Hancock County Society will entertain the Sixth District annual meeting in May.

JOSEPH L. ALLEN, M. D., Secretary.

LAKE COUNTY MEDICAL SOCIETY

April, 1933

A regular meeting of the Lake County Medical Society was held at Gary Mercy Hospital, Thursday, April 13, 1933, Dr. E. S. Jones presiding. Dinner was served by the Sisters of the hospital, at six-thirty p. m. Considering the most abominable weather the attendance was very good, despite the fact that several of our folks, accustomed to late meetings, came in after the session had ended. President Jones has served notice on the membership that all meetings begin at the advertised hour and that when it is announced that a speaker will begin at seven-thirty it means just that.

Announcement was made of the special meeting for April 27th, this being an afternoon clinic, at St. Margaret's, Hammond, to be conducted by Dr. Jos. Colt Bloodgood, with a dinner session at six-thirty, to be followed with a special address by our guest.

An application for membership was received from Dr. Harry Brandman, of Whiting, and same referred to the Council.

Ballot was had on the application of Dr. Carl H. Bendler, he being declared duly elected.

The guest of the evening, Dr. Frank C. Mann, of the Mayo Clinic, a Hoosier by birth and education, was introduced and gave a very interesting discussion of "The Pathological Physiology of the Liver." Dr. Mann proved a most entertaining speaker and held the attention of a large audience as he detailed some of his work in the Department of Surgical Research at the Clinic.

Adjourned.

E. M. SHANKLIN, *Secretary.*
E. S. JONES, *President.*

THE LAKE COUNTY MEDICAL SOCIETY

The following letter was sent to the Committee on the Costs of Medical Care, in Washington, March 29, 1933:

Gentlemen:

The Lake County Medical Society, through a special committee, transmits the following report regarding the final report of your committee:

Our society feels that the medical profession is amply qualified to work out its own problems, gradually, fairly, and safely.

We favor evolutionary methods rather than such revolutionary methods as suggested in the majority report in matters of such fundamental importance.

We, therefore, condemn the majority report and strongly support the minority report of the Committee on the Costs of Medical Care.

J. R. PUGH, M. D., *Chairman, Local Committee*

Attest:

E. S. JONES, M. D., *President.*
E. M. SHANKLIN, M. D., *Secretary.*

ST. JOSEPH COUNTY MEDICAL SOCIETY

The St. Joseph County Medical Society met in the medical room of the Public Library, March 21, 1933, with President Graham in the chair and forty-three members present.

Dr. C. M. Malstaff was elected a member of the St. Joseph County Medical Society.

The subject of prescriptions for medical whisky was brought up. Discussion brought out that the prescribing of whisky was an individual matter and that the same rules should prevail as prevailed in other prescriptions for medicines under therapeutic use. Many men are not even taking out a license to prescribe whisky.

The paper of the evening was presented by Dr. George Rosenheimer on "Oxygen Therapy." Dr. Rosenheimer discussed the various indications for the use of oxygen, its value in anesthesia, the physiologic basis for the therapeutic employment of oxygen, the amounts in which it should be administered, and the beneficial results that may be expected from its use.

The paper was discussed by Drs. Green, Sensenich, Marcus Lyon, and Wygant.

The St. Joseph County Medical Society, with the Tuberculosis League, sponsored a Darden Memorial Meeting at the Oliver Hotel, March 29, 1933, at 6:30 p. m. Seventy-one members and guests attended the dinner with about one hundred additional members and guests coming later for the paper.

President Graham introduced Mr. Woodson Carlisle who outlined Dr. Darden's life from his early medical training to his own infection with tuberculosis which gave him, after his own cure, his intense interest in that disease. Mr. Carlisle spoke of Dr. Darden's recovery; his intensive training in tuberculosis; his service during the war in examining tubercular soldiers; the different positions with institutions for care of the tuberculous which he had held before coming to Healthwin Hospital; and finally the ideals for such a hospital which he deemed necessary to a successful cure, and which he tried to carry out.

Dr. J. A. Myers, Professor of Preventive Medicine, University of Minnesota, gave the paper of the evening on "Childhood Tuberculosis." Dr. Myers illustrated his talk with x-ray pictures of the lungs of the children after they had shown a positive skin test for tuberculosis. He showed pictures of the early focus of infection, then the different stages this focus passed through on its way either to recovery or to its greater involvement of the lung followed by early death. He showed pictures of these children who had apparently recovered but later in their teens suffered either a reinfection from the old focus or a new infection from an outside source. He stressed the point of the easy transmission of this disease from association and close contact with parents or grandparents or other members of the family who may have tuberculosis. He pleaded for more careful isolation of infected cases and also for a routine skin test for all prospective students to colleges or universities or normal schools. He closed with some graphic pictures taken from real life illustrating the number of cases one person with tuberculosis could infect.

Questions asked by Drs. Freyermuth, Fleming, Wygant, Spenner, Gordon Frith, and Edson were answered by Dr. Myers.

At the end of the discussion, Dr. Sensenich briefly outlined the beginning of Healthwin in Potowatamie Park and traced its gradual growth from then to the most up-to-date hospital of to-day, giving Dr. Darden the credit for its greatest development.

The meeting adjourned at 9:45 p. m.

* * *

The St. Joseph County Medical Society met Tuesday, April 4, 1933, in the medical room of the Public Library, with thirty-two members present and President Graham in the chair.

A letter was read from the Executive Secretary of the Indiana State Medical Association asking information about the Royal Bankers Life Insurance Company of South Bend. No such insurance company was listed in South Bend and no one knew of such a company.

In the examination of pre-school children in the spring round-up conducted by the Parent-Teacher Association with the help of the members of the St. Joseph County Medical Society, it was decided to ask the Parent-Teacher Association to give each pre-school child a card to take to his family doctor who would then examine him and make such suggestions as each child should need. This examination is to be done free of charge in those cases unable to pay, or at such nominal charge as each family could pay. In this way it was thought more parents would co-operate in carrying out suggestions.

The paper of the evening "Sterility in the Female" was read by Dr. Marion Hillman and discussed by Drs. Bickel, Giordano and Wygant. Dr. Hillman mentioned the percentage of sterile marriages; absolute and relative sterility; the etiology, diagnosis and treatment of this condition.

MARTHA BREWER LYON, M. D.,
Asst. Secretary and Treasurer

* * *

WELLS COUNTY MEDICAL SOCIETY

One of the best and most instructive meetings of the Wells County Medical Society was held at a dinner meeting, at the Bliss Hotel, Bluffton, April eighteenth. The total number of physicians present was thirty-five.

The speaker of the meeting was Dr. Max Cutler, director of the Tumor Clinic, Michael Reese Hospital, Chicago. Dr. Butler gave a highly interesting and instructive talk on "The Recent Advances in the Treatment of Cancer." He emphasized the following as it pertained to radiation therapy: prolonged treatment; adequate dosage; uniform radiation. Dr. Cutler discussed and demonstrated, by means of lantern slides, the following types of cancer; cutaneous, cancer in the oral cavity, cancers of the breast, cancers of the kidney, cancer of the penis, and cancer of the uterus.

The discussion was opened by Dr. G. G. Eckhart, and other discussions followed by Drs. J. R. Tracy, Don Bowers, M. C. McKain, Allen C. Nickel, and Louis Severin.

The following Bluffton physicians were present: Louis Severin, Max Gitlin, H. D. Brickley, C. H. Mead, A. C. Nickel, C. E. Caylor, H. D. Caylor, T. E. Caylor, G. Morris, and O. G. Hamilton; out-of-town guests were: C. N. Baganz, Uniondale; D. C. Wybourn, Ossian; J. L. McBride, Zanesville; S. D. Beavers, L. E. Summers, and C. C. Rayl, from Decatur; J. C. Grandstaff, F. S. Grandstaff, from Preble; C. S. Black, Warren; O. D. Hinchman, Geneva; H. O. Jones, and W. J. Reusser, Berne; A. M. Kirkpatrick and M. C. McKain, Columbus; W. B. Deems and Don Bowers, Huntington; G. G. Eckhart, Marion; Harold Nugen, Auburn; M. O. Klinger, Garrett; C. V. Rozelle and J. R. Tracy, Anderson.

The officers and members of the Wells County Medical Society wish to congratulate the program committee for the arrangement of this program.

MAX M. GITLIN, M. D., *Secretary.*

* * *

CORRECTION: In the report of the Twenty-ninth Annual Congress on Medical Education and Licensure, page 207, April issue, the statement was made that Europe has three times our population and half the area of the United States. According to recent figures the area of Europe is approximately one-fourth greater than the United States, and the population is approximately four times greater than that of the United States.

BOOK REVIEWS

Books received since April 1, 1933:

THE INCIDENCE OF ILLNESS AND THE RECEIPT AND COSTS OF MEDICAL CARE AMONG REPRESENTATIVE FAMILIES. Experiences in Twelve Consecutive Months during 1928-1931. By I. S. Falk, Ph. D., Margaret C. Klem, and Nathan Sinai, D. P. H. Publication of the Committee on the Costs of Medical Care, No. 26. 334 pages. Cloth. Price $3.00. The University of Chicago Press, Chicago, 1933.

* * *

THE ABILITY TO PAY FOR MEDICAL CARE. By Louis S. Reed, Ph. D. Publication of the Committee on the Costs of Medical Care, No. 25. 107 pages. Cloth. Price $2.00. The University of Chicago Press, Chicago, 1933.

* * *

THE COSTS OF MEDICAL CARE. A Summary of Investigations on the Economic Aspects of the Prevention and Care of Illness. By I. S. Falk, Ph. D., C. Rufus Rorem, Ph. D., C. P. A., and Martha D. Ring; with foreword by Ray Lyman Wilbur, M. D. Publication of the Committee on the Costs of Medical Care, No. 27. 650 pages. Cloth. Price $4.00. The University of Chicago Press, Chicago, 1933.

* * *

INTERNATIONAL CLINICS. Volume I, Forty-third Series. March, 1933. Edited by Louis Hamman, M. D. Octavo 305 pages. 16 illustrations, 1 colored plate. Philadelphia, Montreal and London, J. B. Lippincott Company. Cloth $3.00.

TEN YEARS OF OBSTETRICS AND GYNECOLOGY IN PRIVATE PRACTICE. By John L. Rothrock, A. B., M. D., F. A. C. S., formerly associate professor of obstetrics and gynecology, University of Minnesota. 209 pages, illustrated. Cloth. Price $3.00. Paul H. Hoeber, Inc., Publishers, New York, 1933.

* * *

LIGHT THERAPY. By Frank Hammond Krusen, M. D., Director of the Department of Physical Medicine, Temple University School of Medicine, Philadelphia; foreword by John A. Kolmer, M. D., Dr. P. H., Professor of Medicine, Temple University School of Medicine. 186 pages with 33 illustrations. Cloth. Price $3.50. Paul B. Hoeber, Inc., New York, 1933.

* * *

OPERATIVE SURGERY. By Warren Stone Bickham, M. D. and Phar. M. (Tulane), M. D. (Columbia), F. A. C. S., Former Surgeon in charge of General Surgery, Manhattan State Hospital, New York; Former Instructor in Operative Surgery, College of Physicians and Surgeons (Columbia), in the New York Post-graduate Medical School and Hospital and in the New York Polyclinic Medical School and Hospital, Fellow of the New York Academy of Medicine, and Calvin Mason Smyth, Jr., B. S. M. D., F. A. C. S., Assistant Professor of Surgery, Graduate School of Medicine, University of Pennsylvania; Surgeon-in-Chief Methodist Episcopal Hospital; Visiting Surgeon, Abington Memorial Hospital. Volume VII, including General Index to complete work, Volumes I-VII. 849 pages with 765 illustrations. Philadelphia and London: W. B. Saunders Company, 1933. Cloth, $10.00.

* * *

PRACTICAL HEMATOLOGICAL DIAGNOSIS. By O. H. Perry Pepper, M. D., Professor of Clinical Medicine, University of Pennsylvania; Assistant Chief of the Medical Clinic, Hospital of the University of Pennsylvania; and David L. Farley, M. D., Physician to the Pennsylvania Hospital, Philadelphia; and to the Cooper Hospital, Camden, N. J.; Associate in Medicine of the University of Pennsylvania. 562 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1933. Cloth, $6.00 net.

BOOK REVIEWS

CLINICAL DIAGNOSIS. Physical and Differential. By Neuton S. Stern, A. B., M. D. (Harvard), Associate Professor of Medicine, University of Tennessee School of Medicine. 364 pages. Cloth. Price $3.50. The Macmillan Company, New York, 1933.

This book is in the nature of a syllabus used by the author for eleven years in teaching. It is an excellent manual for medical students and young practitioners who are obliged to make diagnoses by the slow and painful processes of memorized facts and the tracing of clues inch by inch. It is not without delight to a more mature mind as it has an intensely interesting delineation of what flashes through the brain of an experienced physician when examining a patient. One is amazed to recall how much generalized information passes through the filter to leave the residue of a final particular diagnosis. While written primarily for the undergraduate it could well be used as a reference in any puzzling case because signs and symptoms are grouped in fresh and stimulating tables. The chapter on "The Technic of Making a Diagnosis" is a model well worth reading by every general practitioner and is clearly the product of an orderly and well-trained mind.

* * *

THE SEX TECHNIQUE IN MARRIAGE. By Isabel Emslie Hutton, M. D. Cloth. Price $2.00. Emerson Books, Inc., New York, 1932.

The subject matter of this book is handled from a practical view-point. The anatomical, biological, and physiological facts are stated with enough simplicity and clarity that they can be comprehended by the average lay individual. The information should be of value to those contemplating marriage and to those who have entered marriage with a minimum of essential knowledge. To the esthetician, one expert in the matters of taste and the philosophy of the beautiful, the volume would have no great appeal, as it is written more for the instruction of the novice. The foreword, by Dr. Ira S. Wile, outlines the more utopian philosophy with regard to the subject under consideration.

* * *

INTERNATIONAL CLINICS. Edited by Louis Hamman, M. D. Volume I. Forty-third Series, 1933. J. B. Lippincott Company, Philadelphia.

The subject matter of this edition is presented in a very practical manner and should be of interest to every practitioner of medicine and surgery. A wide range of subjects is covered. Its review of recent progress in medicine and surgery, by Dr. A. W. Allen and Dr. D. C. Balfour, respectively, is well worth the time of every student physician.

* * *

THE PELVIS IN OBSTETRICS. A Practical Manual of Pelvimetry and Cephalometry, Including Chapters on Roentgenological Measurements. By Julius Jarcho, M. D., Hastings Hillside Hospital and Sydenham Hospital. 365 pages. Illustrated. Paul B. Hoeber, Inc., New York, 1933. Price $6.00.

This is a very thorough presentation of the subjects in the subtitle of the book. The book is very attractive as is the rule with books by this publisher. There is an extensive bibliography and good index.

There is a historical review of pelvic measurement. All types of pelves are considered and the pelves of many races are discussed individually.

Measurements of the fetal head are discussed with the methods of obtaining them within the uterus. Special emphasis is placed on the value of recent developments in measurements obtained by the use of the X-ray.

Therapeutic suggestions are given to a limited extent for various abnormalities.

The subject here discussed deserves more attention by those attempting to practice the art of obstetrics. The better understanding of nature's methods of overcoming difficulties would help the obstetrical attendant to better help his patient to a normal termination of labor without the often hurried resort to Caesarean section.

This very complete presentation of the subjest should fill a need in obstetrical literature, especially as a practical reference book for the practitioner or student of obstetrics.

* * *

PRINCIPLES AND PRACTICES OF OBSTETRICS. By Joseph B. DeLee, A. M., M. D., Professor of Obstetrics and Gynecology at the University of Chicago; Chief of Obstetrics, Chicago Lying-in Hospital and Dispensary. Sixth edition, thoroughly revised. 1,165 pages, 1,221 illustrations. W. B. Saunders Company, 1933. Philadelphia and London. Price $12.00.

This is the sixth revision of what seems to me the most complete, practical and attractive Practice of Obstetrics in the English language. It represents opinions gained from a large amount of clinical material both in the hospital and in the home. It contains a profusion of excellent illustrations with the addition in this edition of strips of motion picture sequences of delivery processes.

There is an excellent chapter dealing with repair of delivery wounds and episiotomies, and the importance of local anaesthetic is stressed both for normal delivery and Caesarean section. DeLee has done much to popularize the cervical Caesarean section. Mounting opinions indicate its supremacy over the classical.

The Aschheim-Zondek pregnancy test is described, but the much more practical and simple Freidman test using rabbits is only mentioned.

The "key-in-lock" maneuver does not appeal to me as being the best method to deal with forceps delivery of the head in the occiput posterior position. Gentleness is taught in all procedures.

It is written with the general practitioner in mind, recommending conservative, expectant treatment of the average case with especial reference to anti- and aseptic technique. In general the book teaches sane, practical obstetrics.

Second Annual Mid-Year Course

(Nine Hours of Instruction)

Arranged by the

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at

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or exchange? This column devoted to Commercial

ARE YOU looking for a new location? Do you have some equipment that you would like to sell Announcements is free to members of the Indiana State Medical Association. The headquarters office of the Indiana State Medical Association maintains an up-to-date list of locations, practices for sale, and physicians who want to find new situations. Let us help you. Write to your headquarters office, 1021 Hume Hansur Building, Indianapolis.

PHYSICIAN, at present in salaried position as roentgenologist and pathologist in an Indiana hospital, wishes to enter private practice. Graduate of Edinburgh (Scotland) University in 1919; aged thirty-eight years. Practiced medicine and surgery for eight years in South Africa. Experienced in both surgery and x-ray; moderate experience in general medicine and obstetrics. Want to buy the practice and equipment of a retiring physician, or to buy a share in an established practice. Prefer Indianapolis as to location, but other locations will be considered. Address Box HG, c/o THE JOURNAL of the Indiana State Medical Association, 1021 Hume Mansur Building, Indianapolis, Indiana.

THE JOURNAL
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VOLUME XXVI JUNE, 1933 NUMBER 6

ORIGINAL ARTICLES

TRANSURETHRAL OPERATIONS UPON THE PROSTATE

W. N. WISHARD, M. D.
H. G. HAMER, M. D.
H. O. MERTZ, M. D.
W. N. WISHARD, JR., M. D.
INDIANAPOLIS

The 1933 operation of transurethral prostatic resection has not suddenly grown over night, but represents a gradual and orderly evolution which has matured hand in hand with our knowledge of the pathological process underlying the disease, and the slow development and improvement of endoscopic instruments both for the diagnosis and treatment of endovesical disorders. To gather an historical understanding of our present resectoscopic armamentarium one must hark back to 1830 when Guthrie[1] presented to the Royal College of Surgeons a knife concealed in a catheter to sever "bar formed in the neck of the bladder." This represented the simplest type of instrument, merely a concealed knife in a sheath, whose function was to incise, not excise, the obstruction. A prize was awarded to Mercier in 1850 by the Paris Academy of Sciences for his work in perfecting an incisor. We observe a distinct advance in Bottini's[3] platinum cautery blade of 1874, a substitution of Mercier's[2] bare knife.

Formerly working, as it were, in the dark, it was only logical that the next improvement should be visualization of the operation. Wishard, in 1890, used a rectal speculum through a perineal incision by means of which a cautery (Fig. 1) was applied to the prostate. This procedure was reported at a meeting of the American Association of Genito-Urinary Surgeons at Washington, D. C., in September, 1891, and published in the *Journal of Cutaneous and Genito-Urinary Diseases* in February, 1892.[4] So far as he is aware, this is the first reference to visualization of the operative field other than by means of open operation.

Freudenberg[5] applied visualization to his urethral instrument in 1897; Chetwood[6] in 1901 used an instrument without visualization through a perineal incision. Indeed, with the appearance of open surgical attack upon the prostate, the continued advantage of a visualizing urethral instrument for relief of median bar formation and the smaller prostatic hypertrophies was repeatedly recognized. Starting in 1890 and for twenty years thereafter Wishard at times used a cautery and snare (Figs. 1 and 3) through a perineal tube for the relief of prostatic obstruction under view, being among the first to call attention to the subsequent atrophy of prostatic tissue. He also reported the use of the cautery through a Koch's air dilating cystoscope (1902).[4a] His cystoscope of 1900 armed with an adjustable cautery blade of the Bottini type (Fig. 2) had the advantage of visualization through the

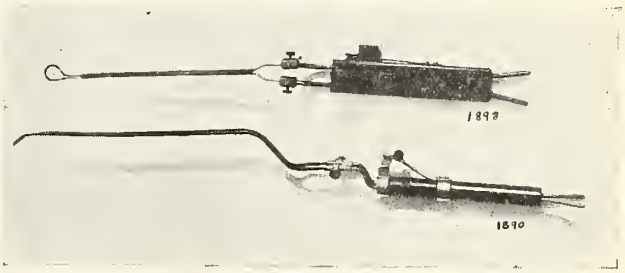


Fig. 1
Above: Wishard's cautery snare for use through perineal tube.
Below: Wishard's cautery knife (1890).
Each used under visualization through perineal tube.

urethra but was later regarded by him as inferior in mechanical construction when compared with Goldschmidt's subsequent instrument. He finally concluded that the electro-cautery's value was confined to a restricted group of cases and should not displace open surgical removal of the larger prostates.

Up to 1909, then, we find the following basic principles involved in the transurethral attack, namely, a knife blade or a cautery, used through an endoscopic instrument under direct visualization for the purpose of incising the obstructing growth. Then it was that Young[7] contributed a tremendous advance by designing an instrument dubbed by his house officers "the punch," which had all the virtues of previous instruments plus the very real advantage of actually removing the obstructing

tissue rather than merely incising it. From that time on advance has been rapid, but has progressed along the line of removing more and more of the obstructing tissue, rather than in the development of any new or basic fundamental principle. Thus we find Stevens[8] in 1913 applying Beer's suggestion of 1910 by fulgurating the vesical neck obstruction with a bipolar high frequency current. Luys[9] in 1913 announced his "forage" of the prostate, and



Fig. 2
Wishard's Cautery Cystoscope, (1902).

Braasch[10] in 1918 devised a modification of Young's punch. It remained for Caulk[11] in 1919 to present a cautery punch which minimized the troublesome factor of operative hemorrhage, coupled with all the advantages of previous instruments, and by means of which he was later (1926) able to report a large series of lateral lobe enlargements successfully removed.

The turn of the tide from the actual cautery, knife, or punch to the use of powerful high frequency electric cutting currents is illustrated by Colling's[12] radiotherm of 1926, used first to cut away fibrotic contractures of the vesical orifice, McCarthy's[13] panendoscopic cutting loop of 1931 and Stern's[14] resectoscope of 1926. Tyvand and Bumpus[15] added a needle electrode to Braasch's punch, coagulating the tissue before punching it out. Foley[16] reported a cystoscopic excisor in 1927, and in the same year Davis[17] designed a more powerful electrical unit which would cut out larger pieces of tissue under water and which was provided with an electrical foot switch whereby the operator could turn from cutting to coagulating (hemostatic) current at will. McCarthy then assembled his panendoscopic cutting device, equipped with the Stern control of the cutting loop, in an insulating bakelite sheath with an open-ended fenestrum, resulting in an instrument which, when used with one of the powerful modern electrical units, removes almost any desired amount of obstructing prostatic tissue. Day has likewise designed a resector, while Kirwin[18] in 1931 used an instrument whose electrode moved in a circular arc rather than to and fro. Brevity forbids description of other useful instruments, both here and abroad, for kindred purposes; lack of technical understanding prevents a critical discussion of the pros and cons of the spark gap and radio tube electrical units.

To the patient, the greatest recommendation for transurethral prostatectomy is that it is accomplished without surgical opening of the bladder. The obstruction to the passage of urine is removed by means of an instrument introduced into the bladder through the urethra. While it simplifies the patient's problem, it is a more difficult procedure than an open operation in its accomplishment. If the punch method is used, whether a cold or a cautery punch is employed, the small field of vision, the expert interpretation of the visual findings necessary, and an appreciation of the limitations of the instrument, make a prolonged apprenticeship necessary before the results of the advocates of this operation can be equaled by the average operator. Foley's instrument which proposes to remove large sections of the obstructing tissue is still in the experimental stage and its ultimate effect upon transurethral operations upon the vesical neck can not now be known. The resectoscope, an instrument intended to remove small ribbons of tissue by means of an electric current passing through a small loop, is the most generally employed at present. The type of instrument, the source of the current, and the mechanical construction of the instruments vary; however, all have in common the ability to cut under visual control. The success of the operation depends upon the removal of sufficient tissue through the taking of repeated bites, to enable unrestricted urination. While the instrument is not mechanically difficult to operate by one acquainted with urethral

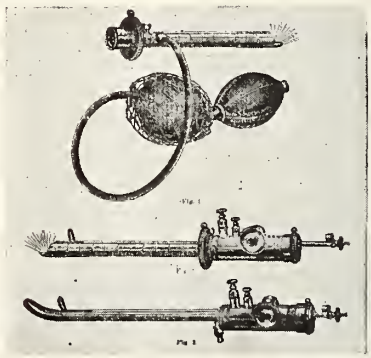


Fig. 3
Above: Wishard's diagnostic tube for inspection of bladder and urethra with obturator removed.
Middle: Wishard's diagnostic tube with cautery.
Below: Wishard's cautery incisor for use without light where conditions impair vision.

instrumentation, interpretation of existing conditions during the operation and judgment as to the extent of the resection necessary to accomplish free urination are not simple. It is a highly technical procedure, and if much tissue is to be removed, or if bleeding should become troublesome, a great deal of time may be necessary to complete the operation. It is a procedure which can be repeated within short limits of time, four of our cases having had more than one resection. Or, should the growth recur in the future the operation can be done again.

HOW UNIVERSAL IS THE METHOD?

The future of transurethral prostatectomy will probably be much influenced by a just appreciation

of the limitations of its applicability to the various types of vesical neck obstruction as met in an average practice. This is at present a difficult question to answer because of the wide variation of opinion among operators as yet. Stern[21] says, "To place the figure of amenable cases at 90 per cent, as several writers have done, is highly misleading. . . . Twenty-five to 30 per cent of all prostatic intrusions are amenable to transurethral resection, and that 60 to 65 per cent are for one reason or another doubtful or frankly unfit."

Day[22] thinks that 35 to 50 per cent of cases of prostatism as observed in average practice, can be resected satisfactorily; that in another 25 per cent, fair functional results can be attained; that, while technically possible in from 85 to 90 per cent of all cases, it is not to be recommended in so high a percentage. Ryall[20] concludes the procedure should not be applied to more than 75 per cent of all cases. Cabot[23] suspects that with growing experience and improvement of technic something like 75 per cent of all cases will, within the next few years, come properly within the field of this operation. Livermore[24] thinks resection the choice in most prostatic hypertrophies. Caulk[25] says that with increasing experience and skill he now finds his punch operation applicable in 85 per cent of all prostatic obstructions, and in January, 1933, he states 80 per cent of all growths, benign or malignant, can be removed by transurethral methods.

This brief review gives an idea of about what proportion of the cases seen with prostatism can be expected to be cured when operated by the authors quoted. All these references are too recent reports, and are quite different from earlier ones, and reflect a somewhat greater conservatism than was formerly expressed—an observation more significant because such change in opinion has occurred in the face of increased skill acquired in the technic of the operation due to greater experience.

We have considered certain type cases as unsuitable for resection, and during the period covered by our use of the transurethral operation we have removed the prostate surgically in forty-nine cases (40 per cent), or during this time we have considered resection feasible in 60 per cent of our cases.

CONTRAINDICATIONS

The introduction of a new method of operation upon the prostate should not in the least result in a lessening of our vigilance and care in the general survey of the patient in deciding if he is surgically fit. If a question exists as to his being so, liberties should not be taken with his life, but he should be treated by the time-proved methods of drainage.

In the acute retention case, difficult to catheterize, suprapubic drainage should be done, and then later, conditions at the bladder neck being suitable, resection may be undertaken.

In the presence of an acute urinary infection, resection should not be done. Under proper preoperative regime the patient's condition will often justify resection later.

In a markedly infected, atonic bladder, one can not expect results from resection alone. Thorough drainage should be instituted before resection, as has been found most satisfactory in finger enucleation in such cases.

In carcinoma extending onto the wall or base of the bladder, especially when the patient has strangury and tenesmus, permanent suprapubic drainage will prove more effectual than resection, both in resulting comfort and duration of life.

From our own experience we believe good sized median lobe hypertrophies can be successfully removed by resection, while it would seem that the very large, bilateral lateral lobe enlargement should best be removed by surgical enucleation. Thus with these contraindications for the employment of resection well in mind, it appears that the greatest value of the operation will be found in those instances of difficult urination, the median bar and the vesical neck contracture forms of obstruction, moderate sized median lobe hypertrophy, small lateral lobe hypertrophy, subtrigonal gland hypertrophies, and in certain borderline patients who have improved following preliminary suprapubic cystotomy. It may also be employed with advantage in carcinoma of the prostate when not accompanied by much bladder distress or extension.

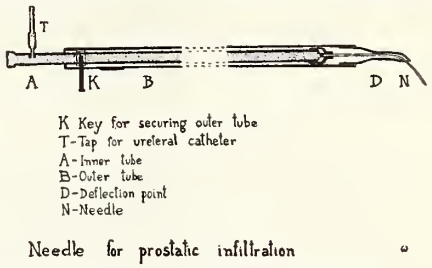


Fig. 4. Instrument devised by W. N. Wishard, Jr.

COMPLICATIONS

Hemorrhage, whether primary and slight, controlled at the time of the resection, or severe, necessitating opening the bladder for its control, or delayed and secondary in character, occurring in from one to three or more weeks after the resection, is a big factor; and our inability to control it adequately is the resectionist's great problem at present. It is possible that electrical shrinkage of the hypertrophied tissue before resection is attempted, as advocated by Stern, may lessen the incidence of hemorrhage.

Infection, local or systemic, may occur. It is probable that an appreciation of the significance of oedema and inflammation of the tissues about the bladder neck will be the greatest factor in preventing this complication. In the serious form there may develop an abscessed kidney, perineal abscess, or a blood stream infection. Failure of a patient to urinate voluntarily after all operative oedema has subsided may occur and further resection be necessitated.

Accidents due to faulty manipulation of the instrument include perforation of the base or wall of the bladder from inaccurate application of the cutting loop, resulting in sepsis and at times death. Epididymitis may prove troublesome. A preliminary vas section will prevent its development.

Postoperative stricture of the urethra may develop, either due to the use of too large an instrument in the urethra, as Day concludes, or to some other cause not as yet appreciated, as was true in two of our cases.

ANESTHESIA

Local infiltration of the prostatic area with novocaine, either by means of a needle on a flexible tube through a cystoscope, as reported by Frischer[19], or by a needle in a resectoscope after the manner of Ryall[20], gives satisfactory anesthesia in some cases.

In experimenting with these methods, both of which utilize needles, operating in a direction approximately parallel to the long axis of the urethra, we found it difficult to deflect the needle sufficiently to penetrate deep enough into the prostatic tissue to infiltrate the larger obstructions. A needle whose construction is shown in the accompanying illustration (Fig. 4) was therefore devised by W. N. Wishard, Jr., which could be deflected at an acute angle to the resectoscope and which was long enough to penetrate the prostate sufficiently to anesthetize the deeper portions of the tissue about to be resected.

The principle of this instrument is simple. An outer tube, with a small bent deflecting tip through which an inner needle passes into the fenestrum of the resectoscope at an acute angle, is of over all dimensions the exact size of the cutting loop used to remove the prostatic tissue. This tube is secured against rotation and slipping by a key which fastens to the rack at the back of the resectoscope and over the end of this outer tube. Within this outer tube is an inner one, and on its outer end is a detachable, rustless steel, 25-gauge dental needle. When the device is inserted in the cutting electrode slot on the lower side of the resectoscope, the back end of the inner tube is screwed into the movable handle. Into the side of this tube screws a small nipple to which a ureteral catheter connects it to a 10 cc Luer syringe. The instrument is used in the Stern-McCarthy resectoscope without any alterations in the latter. The needle is operated under direct observation with the handle of the resectoscope which ordinarily controls the cutting electrode.

The purpose of this paper is not to go into details about the technique of local infiltration, which will be reported later. However, we have resected over twenty cases under this anesthesia, and in only one patient (an early one in the series) have we been compelled to resort to a supplementary anesthesia. At present we are using local infiltration almost exclusively with eminent satisfaction to the patient and to ourselves, thereby avoiding much of the immediate risk of spinal, sacral, or inhalation anesthesia.

MORTALITY

It is difficult in many instances of resection to know what influence the operation may have had upon a patient's death. As the literature accumulates, however, it becomes more evident that the operation is not without its own mortality rate, which must vary inversely with the operator's training and experience. It is encouraging to note that in a review of the reported instances of death, had the limitations for the employment of the method, as now advocated, been followed, the death rate directly attributable to the operative procedure would have been much lower. It is still more important to note that with the early workers in this field, in their most recent reports, the death rate is decreasing, indicating a better understanding of the problem involved in a successful resection, and an increase in their skill in performing the operation. This is best illustrated in the statistics of Alcock[26] who lost eighteen patients following resection in one hundred seventy-five cases. Lewis,[27] in a questionnaire, recently collected a series of eighty-seven deaths. Day,[27] in seventy-four resections, had three deaths, while Kirwin[27] lost three of eighty patients.

That transurethral operations, even in their present day perfection, are entirely devoid of danger, an impartial observer can but deny. The current wave of popularity now accorded this method is in part at least fostered by commercial enterprise giving the procedure a "wide publicity to the medical profession," propaganda which studiously endeavors to minimize the danger of the operation as well as to encourage its indiscriminate employment. Unbiased, forward-looking urologists have accepted the method, employing it in their daily work but withholding their final decision as to its advantages and limitations until they have accumulated sufficient experience to justify such an opinion. To enable an early understanding of the procedure's possibility for good or harm, all operators should give a true recital of their experiences. This knowledge is imperative that the general physician and the operator may benefit the patient in their decision as to the method suitable for a given case, especially as the present reaction of the profession to the operation is in part founded on an apparently false appreciation of its gravity.

Inasmuch as many of our cases have been done in the recent past, we deem it unwise to proffer our final opinion about the ultimate efficacy of the operation in relation to the permanent cure of the patient, directing our attention rather to his immediate course in the hospital both as to preoperative treatment and the operation itself, coupled with the postoperative hospital period.

This report is based upon eighty-four operations for transurethral relief of vesical neck obstruction in seventy-four patients. Twenty of these were by punch, and sixty-four resections. During this

period forty-nine suprapubic prostatectomies were done.

The average age of the patients subjected to transurethral operations was sixty-five; the oldest being ninety and the youngest twenty-seven.

The average stay in hospital was 29.8 days. The longest stay was one hundred ninety-four days. The shortest stay for resection was four days. Two patients went home the same day a punch operation was done.

Postoperative complications include epididymitis (6), postoperative hemorrhage (4), incontinence (2), perineal abscess (1), extravasation of urine (1), angina pectoris (1), cononary occlusion (1), pyonephrosis (1), hypostatic pneumonia (1), pyelonephritis (1), erysipelas (1), and phlebitis (1).

Associated lesions included vesical calculi (11), vesical diverticula (7), carcinoma of bladder (3), renal calculi (2), prostatic calculi (2), renal tuberculosis (2), urethral stricture (2), and suprapubic fistula (1).

Of the seventy-four patients, thirty-three, or 44.6 per cent, had complete retention of the urine.

There were fourteen, or 19 per cent, cases of carcinoma of the prostate.

Mortality—Four of the seventy-four patients died following operation, a mortality of 5.4 per cent. The causes of death follow:

1. Cancer of the prostate; died ninety-three days after punch operation, of pulmonary tuberculosis.
2. Cancer of the prostate; died thirteen days after resection, of hypostatic pneumonia.
3. Adenoma of the prostate; died forty-eight days after resection, of coronary occlusion.
4. Adenoma of the prostate; died sixty-one days after resection, of uremia due to pyonephrosis.

Several of the series had multiple operations as follows: Suprapubic lithotomy and resection; suprapubic lithotomy and punch (2); suprapubic prostatectomy (one year before) and punch; suprapubic cystotomy and resection; suprapubic prostatectomy and punch; punch and resection; suprapubic cystotomy, one punch and two resections; prostatectomy and resection; suprapubic lithotomy and three resections; suprapubic cystotomy and three resections; suprapubic prostatectomy previously and resection; two resections; suprapubic prostatectomy, punch and resection; suprapubic prostatectomy (six years before) and resection.

The types of vesical neck obstruction in these cases include contractures, bars, varying grades of hypertrophy of median and lateral lobes up to grade four, carcinomata of the prostate and contractures and nodular obstruction following prostatectomy.

Conclusion

The morbidity and mortality of suprapubic and perineal prostatectomy can be compared favorably to those of other major surgical procedures. Nevertheless, any new method of treatment of vesical neck obstruction which would lessen either will be eagerly accepted by urologists. If it should further shorten the period of hospitalization, lessen the cost and be accompanied by less pain and discomfort during convalescence, it would have much to recommend it to both doctor and patient. Transurethral resection of the vesical neck seems to answer favorably these requirements.

Only time will tell if it is ultimately to be classed as a palliative or a curative measure. While in the final analysis its applicability to all types of bladder neck obstruction may be much restricted, from the present tendencies it gives evidence of certain distinct advances over older procedures which will remain to enrich our methods of treating this disease.

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THE ROLE OF GLUCOSE IN DIAGNOSIS AND THERAPY*

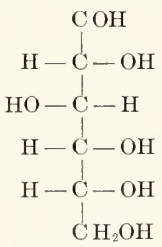
W. P. Moenning, M. D.
Indianapolis

The importance of glucose in the metabolism of living tissue is an accepted fact. With time this sugar plays an ever increasing and important role in the diagnosis and treatment of disturbed physiological processes; therefore, I feel that a brief review of the subject, as we understand it today,

* Presented before the annual session of the Indiana State Medical Association at Michigan City, September, 1932.

should be of interest to all physicians whether they are specialists or general practitioners.

Glucose is a monosaccharide and has the following formula (Fig. 1). Sometimes it is referred to as dextrose. Nature has distributed glucose very widely, as it is found in all foods, as such, or can be derived from foods by simple chemical processes. Carbohydrates yield 100 per cent glucose and it is possible to derive 58 per cent of glucose from protein and 10 per cent of glucose from fat. The nourishment of any living organism can be divided into these three major food constituents. The normal physiology of glucose in man is now pretty well understood. The digestive action of carbohydrates is started by action of saliva and primarily finished in the bowel. From the latter, glucose is taken up by the portal vein. The protein is split up into simple products by the gastric and intestinal juices, carried via the portal vein to the liver where the chemical conversion to glucose takes place. This same process is true for fat. From the liver, glucose is distributed throughout the body, part of it being stored in the liver as glycogen, and part stored in the muscles as glycogen. Part is oxidized to produce heat and energy, and a portion of the glucose is converted into fat. There is constantly a fairly even average amount of glucose in the blood—varying in the normal individual from 85 or 90 mgms. to 120 mgms. per 100 c.c. of venous blood, the amount depending upon the ingestion of glucose. Regardless of the place of distribtuion of glucose it is eventually oxidized to carbon dioxide and water. There is some evidence that this takes place under two different environments: (1) aerobic; (2) anaerobic. In the former, the end products are as has been stated. In the latter, lactic acid is the end product and this in turn is oxidized into carbon dioxide and water. Muscle activity produces lactic acid. It has been proven, beyond a doubt, that insulin, an internal secretion from the Islands of Langerhans in the pancreas, must be present to properly burn glucose. With these facts, it is easy to understand that disease conditions may arise where glucose plays an important role:



d — Glucose
(Dextrose)
(Grape sugar)

Fig. 1

(1) Starvation.

(2) Obstruction in the upper portion of the alimentary canal.

(3) Inability to use glucose, even though it is obtainable, resulting in either excessive amount of glucose in the blood, as in diabetes mellitus, or resulting in a very low blood sugar concentration, as in renal diabetes.

(4) Inability to store glucose for further demand, as in certain types of liver diseases.

(5) Inability to burn glucose, for example, in cases of diabetes.

(6) Burning glucose too rapidly, as in cases of tumor of the pancreas.

(7) Acidosis, resulting from incomplete combustion of fats, is associated with inability to burn glucose, are a few of the examples of disturbed biochemistry that are now better understood and easier to diagnose and, therefore, simpler to treat.

Each individual seems to respond to the ingestion of glucose in a definite, uniform manner. In fact, the glucose tolerance test (curve No. 2) is so characteristic that any deviation from normal can be easily determined and is valuable as a diagnostic aid. Ordinarily, the tolerance test consists of giving an individual 100 grams of glucose, either as such or in a meal containing 100 grams of available glucose or sometimes 1 gram of glucose per kilogram of body weight after a 12-hour fast (usually in the morning before breakfast), and of determining the amount of glucose in the blood before the administration of glucose, one-half hour after meal, one hour after meal, one and one-half hours after meal—this for hourly intervals for two or three hours. The results may be graphed and we have the curve which may be compared with the normal.

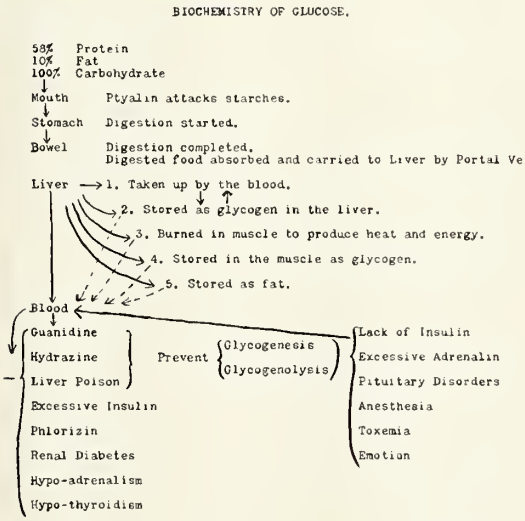
In addition to the blood examination, it is advisable to test the urine at hourly intervals while the test is in progress. If we have a patient free from sugar when the test starts and if we calculate the amount of glucose loss in the urine, by the simple processes of addition and subtraction we can estimate the patient's glucose tolerance. The normal, healthy individual of average height and weight should be able to tolerate 100 grams of glucose without showing sugar in the urine and the venous blood sugar curve should start from initial normal blood sugar level, reach its height in from one-half to one hour after the glucose administration and should recede to the initial starting point or even below at the end of the second hour. One must take into account in reading the curves the form in which glucose was administered because when the glucose is given in the form of a diet of 100 grams of available glucose, time must be allowed for digestion and absorption. This usually requires one hour. In interpreting, therefore, a venous blood sugar curve where a meal has been given, one finds that the height of blood sugar is reached within one and one-half to two hours after and recedes to initial blood sugar level or below within one hour after the highest point. In cases where there is a melituria we find that this begins after the concen-

tration of glucose in the blood has reached a certain level. This is ordinarily referred to as the renal threshold and in the normal individual this is 160 to 200 mgms. per 100 c.c of blood. It has been found that the renal threshold is sometimes elevated and sometimes lowered in disease. Certain diseases have characteristic venous blood sugar curves and as time progresses the glucose tolerance test is found to be very valuable as a diagnostic aid. This test can be used to calculate the dietary prescription in those cases showing disturbed glucose metabolism.

Indications for glucose tolerance test:

(1) Cases of glycosuria.
(2) Sudden obesity.
(3) Cases to determine severity of diabetes.
(4) In cases of familial diabetes.
(5) Hypo- and hyper-thyroidism.
(6) Addison's disease.
(7) Pituitary disorders.
(8) In all types of vague cases where there is an element of nervous exhaustion.

The following diagram gives a summary of the train of events in glucose metabolism and the elevation and lowering of blood sugar as found in certain clinical conditions.



The therapeutic uses of glucose can best be understood by considering the various diseases and disturbed psychological processes. A lack of glucose, as in starvation, plays an important role. Starvation, due to lack of food, due to inability of food to reach the digestive tract, due to inability to retain food long enough for absorption as in vomiting and diarrhea, is characterized by an inadequate supply of glucose and the proper therapy consists of supplying glucose.

In liver diseases we have an inability to convert glucose to glycogen, and an inability to store glycogen in the liver. Even guanidin and hydrazine as well as other liver poisons interfere with proper glycogenesis. In hepatic diseases at best, we can only hope for glucose to act symptomatically as long as the disease process is present or until the liver poisons can be obliterated.

In pancreatic disease the patient may burn sugar too fast or may not be able to utilize glucose at all. The former condition is due to excessive amounts of natural insulin while the latter is due to inadequate amounts of natural insulin. Hyperinsulinism has been reported quite frequently in recent journals; the author has seen one such case. In this condition it is theoretically possible to save the patient, providing the excessive insulin-producing mechanism can be corrected. The removable types of pancreatic cyst cases are examples of cures. The administration of glucose certainly maintains life longer, even though the case is inoperable. The life prolonging use of insulin in hypo-insulinism or diabetes need only be mentioned as all, no doubt, have had personal experiences with this condition, and have marveled at the results obtained.

Natural insulin may be antagonized or rendered useless by what is thought to be an adrenalin reaction. Hyper-adrenalinism or conditions favoring excessive adrenalin production seriously interfere with glucose metabolism. It is thought that certain pituitary diseases, thyroxin, anesthesia, some toxemias, and certain emotional disturbances unbalance the glucose metabolism through the help of the antagonistic action of adrenalin on insulin. If this be true, it is easily understood why the use of glucose with insulin many times spells the difference between success and failure.

The time may come when it will be a proven fact that some hyper-insulinism cases with their low blood sugars will be explained on the basis of hypo-adrenalinism.

The symptoms of low blood sugar are very numerous. The author has seen gastric ulcer symptom complex and fainting attacks relieved by eating some form of easily assimilable glucose.

To date there is no adequate explanation for renal diabetes.

The use of glucose in shock, toxemia, eclampsia, post-operative dehydration and starvation, need only be mentioned in passing.

The author believes that an understanding of the physiological chemistry of glucose metabolism together with calling attention to the multitude of diseases where the glucose metabolism is disturbed or where the judicious use of glucose is of decided therapeutic value warrants twenty minutes of any doctor's time. Further, the time will come, I believe, when a blood sugar determination will be a part of every routine examination.

DISCUSSION

A. C. NICKEL, M. D. (Bluffton): I would like to emphasize glucose therapy in cases of angina pectoris or coronary sclerosis.

About a year ago I read an article written by G. Hubert, claiming that glucose intravenously would relieve the symptoms of coronary sclerosis.

We have tried this form of therapy in ten or twelve cases that were diagnosed as such by the cardiograph, and have had several very gratifying results.

After a series of intravenous glucose injections (fifty to one hundred cc. of a 25 per cent solution of glucose) the patients have a sense of well-being and the sensations that usually accompany coronary sclerosis are ameliorated. The intravenous medication was the only treatment used in these cases and the cardiographs, after a month's treatment, showed definite improvement.

I have done no work on experimental animals to prove or disprove this action, but it at least has helped clinically and I think this would be an added use for glucose therapy.

H. M. BAKER, M. D.: At what intervals did you use it?

A. C. NICKEL, M. D.: We started the injections every other day and gradually increased the interval until it was one week.

ROSCOE SENSENICH, M. D.: What were the cardiograph changes?

A. C. NICKEL, M. D.: The lengthened "Q" and the S. T. interval. The lengthened "Q" when present became shortened, and the S. T. interval, which was depressed or elevated, returned to normal. I have not traced the patients longer than four months at the most. Anything that will help these patients is worth while.

J. H. WARVEL, M. D. (Indianapolis): I enjoyed Dr. Moenning's paper very much. I think that we are all beginning to appreciate more and more the value of glucose in both diagnosis and treatment.

Dr. Moenning has introduced one term here which is comparatively new, and that is hyperinsulinism. Dr. Seale Harris, in 1924, at the Chicago meeting of the A. M. A., presented some very interesting case reports, of patients on whom he had made a diagnosis of hyper-insulinism. At that time it was rather difficult to believe that there could be such a condition. The case reports of his patients brought out the following predominant symptoms: Weakness, hunger, loss of strength, and fatigability, oftentimes associated with excessive perspiration, and at times irritability, or a marked inward nervousness on the part of these individuals. They were the type of case which presented symptoms in many instances which were suggestive of a neurosis of one type or another. Some of them presented symptoms suggestive of focal infection, early pulmonary tuberculosis, or even early hyper-thyroidism. Dr. Harris at the time was impressed with the similarity of symptoms which these patients presented, to the symptoms which he had observed in patients who had received an overdose of insulin. He also found out that these patients oftentimes presented rather low blood sugar findings.

Since these facts were first called to the attention of the medical profession, a number of other investigators have written in regard to hyper-insulinism occurring in varying degrees. In some cases the symptoms are so mild as to escape the attention of the physician. Still others present marked weakness and nervousness coming on at regular time intervals after each meal, or following vigorous exercise. In a third group of cases the symptoms are so marked that the patient may pass into a state of coma, such as observed in insulin over-dosage. The blood sugar is found to be as low as twenty to thirty milligrams per 100 c.c.s of blood.

Individuals who present the milder type of symptoms oftentimes discover for themselves the fact that the taking of food relieves all their symptoms. Candy, orange juice, or any carbohydrate food is all that is necessary.

In the extreme cases presenting a coma resembling insulin shock, there is usually found a new growth such as an adenoma or carcinoma of the pancreas. A few cases have shown only hyperplasia of the Islands of Langerhans. This type is usually benefited by surgery.

I would like to describe briefly a case that I had an opportunity to observe about one and one-half years ago. This woman was sixty-eight years of age, and had a very severe diabetes. She was using a carefully weighed diet, and found it necessary to take from 80 to 100 units of insulin a day to keep her blood sugar normal and her urine sugar-free. Suddenly, for some unknown reason, she began to develop symptoms of insulin overdosage, and I thought that she was possibly taking too large a dose of insulin due to a change in strength of the insulin used, or that she was getting an overdose of insulin because she could not distinctly make out the markings on her insulin syringe. In the beginning, reactions could be overcome by the prompt administration of orange juice, or some other quickly available carbohydrate by mouth. Later on, as the reactions became more marked, it was necessary to give her glucose intravenously, in order to afford relief. Her daily dosage of insulin was reduced quite rapidly, but she continued to have reactions, and occasionally would become comatose. Finally her insulin was discontinued entirely, and much to my surprise she continued to have severe insulin reactions, even passing into a state of unconsciousness. A graduate nurse was assigned to take care of her diets, and to watch her closely for insulin reactions, and oftentimes the symptoms would come on so quickly that the patient would pass into a stupor before the nurse was aware that she was having a reaction. We finally arranged to have her given glucose in some form every two to three hours, both day and night, in addition to her meals. In the course of a month or two the patient began to lose rapidly in weight and strength. She developed a marked diarrhoea, fatty stools, and considerable pain in the upper abdomen. A diagnosis of pancreatic tumor was made. The patient lived for about four months from the time that she first

presented symptoms, and at the time of her death an autopsy disclosed that she had an adenocarcinoma of the pancreas. There was evidence of metastasis to the liver.

A number of cases similar to this have already been reported in medical literature, among them the cases of Dr. Wilder, of the Mayo Clinic; Dr. Rabinovitch, of Montreal; and Dr. Thalhimer, of Milwaukee.

I think that all of us see cases of mild hyperinsulinism almost every day. In most of these cases we possibly make the wrong diagnosis, thinking them to be a simple neurosis or hyper-thyroidism, or some other more easily recognized condition. The correct diagnosis in these cases can be made by a careful history, the finding of a low blood sugar, and the prompt relief of symptoms following the frequent administration of glucose by mouth.

H. M. BAKER, M. D. (Evansville): Substantiating the discussion of Dr. Warvel, it was my good fortune (or bad luck) some months ago to see the wife of a physician who had been repeatedly diagnosed as psychoneurosis. We finally made a diagnosis of hyper-insulinism and narrowed the condition down to a pancreatic tumor. She was sent to Dr. Evarts Graham, of St. Louis, who successfully removed the adenoma from the pancreas, and she is now gaining weight. Her neurosis has cleared up.

W. P. MOENNING, M. D. (closing): I think any drug or therapeutic agent that is used so often, and talked about so much, usually has one of two things to happen to it: we either decide that it is just our idea that it helps, or that we are sort of fanatical about the particular drug or therapeutic agent. For that reason I felt that a review of the chemistry of glucose and a citation of a few of the diseases where there is either an excess or a lack of glucose, would certainly be in place.

Furthermore, to walk into a room and see a lot of empty Karo cans, to have a patient unconscious, and to have the family tell you that as soon as they give the patient three or four tablespoonfuls of Karo syrup he wakes up; then to get a very low blood sugar, to give glucose intravenously and have the patient arouse and talk to you—it certainly is spectacular.

At times unconsciousness may be due to the excessive amount of glucose present in the blood. This is not necessarily associated with an acidosis; and, on the other hand, hyperglycemia is not always associated with a glycosuria or with sugar in the urine. One particular case I have in mind presented primary cardiac symptoms that showed, after an exhaustive study, nothing but a high blood sugar, and that improved upon the proper diet.

We all, no doubt, have a lot of nervous patients, and we many times exhaust our own patience trying to decide what to do with these cases. It is my feeling that in some of these cases we are dealing with a low blood sugar and that a thorough study of glucose metabolism might afford these patients relief.

MEDICAL ECONOMICS FROM THE STANDPOINT OF HOSPITAL ADMINISTRATION*

MR. PAUL FESLER†
CHICAGO

I think it is appropriate for someone representing the hospitals to appear in the programs of the various state medical associations in order that we may become acquainted with the work which the hospital is trying to do to aid the medical profession in solving its problems. One of your previous speakers has called attention to liaison groups which are in a position to help the medical profession in fighting their battles. I believe the hospital is one of the most effective agents through which you have to work. If you could get all the boards of trustees and those responsible for the conduct of hospitals, and the patients in the hospitals, to understand the efforts of the medical profession to serve the public in better ways, it would be of material aid to your cause.

During the past year I have been serving on a committee endeavoring to influence the government to care for veterans in civilian hospitals. I have served with Dr. Crockett and have enjoyed knowing him. His activity along this line has meant a good deal to the hospitals, the medical profession, and the public.

I have been asked to say a few words on medical economics and the hospital. The hospital is the workshop of the doctor. Most hospitals are created by the medical profession. The hospital is no stronger than the staff, and the work of the hospital must be entirely based upon the efforts of the staff for the good of the patients. The patients' interest must always be paramount.

In this state you have a large number of small hospitals, most of them owned or at least controlled by doctors. Most of these hospitals are having financial troubles. They have been taken as a matter of course by the public rather than as a part of the community service such as the school, the church, the fire department, or the jail. I think this has caused the public to look at them as public service agencies, such as light and gas companies, rather than as public necessities. I therefore think it is up to us to educate the public that the hospital is a necessary part of the community, and if it is to be successful it must be supported by the public, not only morally but financially.

During the past few years we have seen many committees working in connection with medical problems. The Committee on the Costs of Medical Care, the Grading Committee, the White House Conference on Child Welfare, and other large groups, all have been working and looking into

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the matter of medical and hospital practice. Advance reports from these committees have caused the public to take an interest in this matter and many articles have been published in lay magazines and newspapers which have been not altogether favorable to the hospitals and to the medical profession. The public has for some reason or other taken this to mean that it is entitled to care from these institutions, whether able to pay or not. They seem to forget that medical care does cost something—more than the average person is able to pay. These reports show that the average cost for caring for one person in a hospital is about five dollars a day, and we know that 80 per cent of the families in this country earn less than $1,200 a year, so that the great majority of people cared for in these hospitals is unable to pay for care, which is another reason why the public will have to take this responsibility. I think it is proper, if the hospital wishes to care for patients for less than cost, that the public should pay the amount lost in caring for those unable to pay. The same thing is true in connection with medical care. These insurance schemes throughout the country would be all right if the public would pay the doctor's fees and pay the hospital fee for the care of the patient, or at least pay the cost to the hospital.

The time has come when the public must quit asking the medical men to give unlimited time and service to patients in public hospitals without paying them for their time. I happened to be the superintendent of a state university hospital, and one year I went before the legislature and called attention to the fact that if all of our doctors had been paid $25 for each medical case and $50 for each surgical case, that in one year they would have earned $250,000 for their services. It seems to me that the time has come when we will have to insist that the doctors caring for patients in public institutions have a right to payment as well as other people. The medical profession should insist that methods of relieving the poor should include remuneration for medical care. The doctor is really paying with his time, effort and money in order that the indigent may have proper medical care. I think it is time to stop this. It is also time for us to clean our own houses. We know that the hospitals are just about 60 per cent occupied—public, 90 per cent; private, 50 per cent—and many with a capacity of fifty or sixty beds have ten or fifteen patients—largely because the indigent patients are cared for in public institutions. I think not another bed should be provided for in public institutions until the private hospital beds are filled.

Most hospitals are dominated by doctors. If the doctors are not satisfied with the superintendent of the hospital, the superintendent of nurses, or the head nurse, they have enough influence to see that he is replaced by some other individual. I believe that the medical profession should have that privilege because it is our duty to serve you in your work. It is possible for us to cut out some of the duplications. This past year I have been in practically all parts of the United States. In most communities there are two or three hospitals equipped with x-ray, laboratory, and diagnostic facilities, all with a personnel able to use the equipment. In practically every community one hospital would be able to serve the people. All the x-ray and laboratory work could be done in one hospital. All of the money for personnel, for laboratory and x-ray equipment, etc., comes out of the doctor's pocket. I think it is to the interest of the medical profession to take an interest in hospitals and insist that some of these hospitals be closed. At the Wesley Hospital we had 250 beds, and now we have patients for 125 beds. We have closed the third floor, and if it is necessary we will close the fourth floor and put the patients into smaller space so that less help can take care of them. In other words, cut down the overhead expense. As long as we have all the duplication in the way of equipment it will be impossible. In some towns where I have been they have had a good hospital with complete equipment, and yet when I went into a doctor's office or clinic I found he had x-ray equipment, laboratory equipment, physical therapy equipment, and a personnel unit to handle all this, when all that work could have been done in the hospital at less expense to the doctor. I know many doctors' offices with a great deal of equipment where the work could be done cheaper somewhere else. I am mentioning some of the practical things which I feel should be done in order to see that the patients receive care at less expense, and that the doctor receives a legitimate fee for his services. You know the average patient pays the hospital first and the doctor last, but if the hospital did not get the money first it never would get it. It is true that very few people who leave the hospital without paying their bill ever do pay, because by the time they are ready to pay they are sick again and have to enter another hospital. If you can cut down this overhead expense it will help the doctor get his fee.

Some of you men come from Indianapolis and large cities, and some come from small towns—you are working in all classes of hospitals. It has been my experience that the problems of the large hospital are really easier to solve than the problems of the small hospital. It is absolutely necessary to have hospitals in small communities. Sometimes the cost is very great, but it is a service institution and must be there. In the larger cities you "let George do it"; you leave it to the board of trustees and the management of the hospital; but I think the medical profession could influence all of these hospitals by pointing out some of the things I have mentioned, some of the ways to make it possible to give the patients care at less cost. That is what you want, I know, because there are doctors in my office every day asking if we cannot cut

the rates for this or that. The way to do it is to influence the board to look at these things in a practical way, so that the patient gets the benefit of all of the equipment available. In the small hospital it is up to the medical profession to become interested in that hospital, to go to those responsible for the distribution of taxes and to see that the small hospitals are paid for the care of indigent patients. Many county hospitals have been closed during this depression in order to cut taxes, at a time when they should be giving a maximum of service. This is all right if the patients are cared for in some way, but you should see to it that these counties support at least a small hospital for the care of the indigent, preferably the private hospital.

In regard to the question of nursing, it has been absolutely proven in every small hospital where it has been tried out that it is much cheaper to operate a small hospital with graduate nurses than to run a training school. I know of some hospitals with twice as many nurses in their training schools as they have patients. In this country we have over 2,000 nursing schools, more than half of them in hospitals of less than fifty beds, where it is impossible to give good training to the nurses.

I hope I represent the majority of hospital superintendents in this country when I say that our only desire is to help the medical profession to give their patients the kind of service to which they are entitled.

CURRENT TRENDS IN MEDICAL PRACTICE*

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Of recent years the subject of economics has been given increasingly greater attention by the medical profession. At one time it was impossible for physicians in some parts of the country to arrange meetings for the purpose of discussing medical economics; it was considered unethical to discuss such matters. Times have changed, and at present there is some danger that economic questions may be influenced by emotion rather than by careful thinking. Not more than a half century ago medicine was practiced largely by the use of the five senses, plus whatever instruments or medicaments the physician could carry in his handbag. A suitable history and a careful physical examination were considered all that was essential in making a medical diagnosis. The temperature was taken by placing the hand on different parts of the body. Fifty years ago, and perhaps even more recently, the sense of smell was used extensively to determine the presence of exanthemata.

The next change in medical practice was a definite shift from the five senses to the various kinds of laboratory technique. As the laboratory period became established all of the cells, tissues, secretions, and excretions of the human body were subjected to laboratory examination or microscopic study. The next development to assist diagnosis and treatment was the x-ray, which opened to human observation the hidden cavities of the body. Before that time physicians could listen to the rales within the chest, but with the advent of the x-ray they could see the pathology which was responsible for the rales. As the various perfections of roentgenology were marshalled into the practice of medicine, and as the numerous processes of laboratory technique were developed, the five senses of the earlier practitioners were not only magnified, but they were extended, and they were increased a thousandfold, so that it became easy to make a diagnosis and diagnoses were perhaps in some instances much more accurate.

As a result of these scientific advances knowledge accumulated so rapidly and in such vast amounts that it became impossible for any single physician to know and to apply all these refinements in his private practice. We find the general practitioners of earlier times becoming the specialists of today. The first specialists were developed in the field of eye, ear, nose and throat. In 1925 there were approximately 15,000 specialists of all kinds; in 1928 there were 18,000; and in 1930 there were 40,000. In 1915, 30 per cent of all graduates were becoming specialists; in 1920, 51 per cent of all graduates were limiting themselves to specialties; today three-fourths of all the students in medical schools decide some time during their junior or senior years, the specialty they are to practice when they become licensed.

When roentgenology and certain of the newer methods of diagnosis were developing, the equipment for such work was very cumbersome and very costly. It was then necessary that patients be taken to the equipment, in order that the benefit of these newer methods might be secured. Now such equipment is greatly improved and much of it is easily portable so that it can be taken to the home or sick room. The former practice has thus been reversed.

From 1900 to 1930 there was an increase in hospitals from more than 1,000 in 1900 to more than 7,000 in 1930. In 1900 there were 421,000 hospital beds; in 1930 there were 950,000 hospital beds. In 1920 there were 3,000 x-ray and clinical laboratories for the purpose of reducing the stay in the hospitals; in 1930 they had increased that to 4,000. In 1920 there were 2,500 x-ray laboratories connected with hospitals; in 1930 there were 5,000 x-ray departments in hospitals. A few years ago 90 per cent of all cases of disease were treated by the general practitioner. Fifty-five per cent of these were treated in the home; 35 per cent in the physician's office, and only 10 per cent were treated in the hospital. Now, more than 100,000 physicians in the United States have some kind of hospital

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connection or affiliation. It is believed that 90 per cent of all cases of disease can still be treated by the general practitioner with the amount of equipment that he can carry in his hand-bag; but the remaining 10 per cent require all of the newer methods and refinements of diagnosis and therapeutics, and all of the skill that the modern physician can bring to bear upon the case.

During the period of less than half a century the practice of medicine has changed from an individual, independent, general practice, chiefly, to a practice in which the specialist is rapidly becoming, if he is not already the dominant figure or limited practitioner.

Much has been said and written in recent years concerning the quality of medical care received by the various classes of the population. The population has been divided, perhaps arbitrarily, according to income, namely, the rich, the poor, and the so-called middle class. It is claimed that the poor and the rich receive the best of medical care and that the large class of working people, whose income is small, find it extremely difficult to get the type and quantity of medical care which they deserve and need. Although we must admit that good medical care is essential to happiness, and should be available for what the individual can afford to pay, it is necessary to make a distinction between good medical care, or that which is necessary and appropriate for the particular case, and the best medical care. The best medical care may never be available to all the population, at all times, for the amount they can afford to pay. It must be admitted that it is not always necessary to apply all of the methods of diagnosis and treatment to a particular case. It seems then, that we should rather strive toward that time when all of the people will receive the best care that can be furnished for the amount they can afford to pay. Perhaps this can best be illustrated by the cost of railroad transportation. One can buy a railroad ticket that will take him from New York to San Francisco safely, the thing which he expects it to do. If he buys a coach ticket, it will be necessary for him to sit up all the way. With a little more money he can buy a tourist ticket, which will give him more comfortable accommodations. For still more money he can buy a Pullman ticket that will provide a berth in which to sleep. Or if he wishes to pay the price, he can buy a compartment or a drawing room. If he desires to get to his destination more quickly and is able to pay the fare, he may travel by air transportation. Anyone of these means will take him from New York to San Francisco, safely, but for increasing degrees of comfort or luxury and saving of time he must invest more money.

There have been many experiments during the last few years in methods of administering medical care. Many communities are now supporting some forms of medical practice which are recognized by those who are competent to judge as unsatisfactory, inadequate, and not economically sound. For example, there are: Lodge practice, mutual benevolent associations, insurance schemes of various kinds (although they are not always labeled as insurance schemes), and flat-rate monthly schemes for medical care under contract that have been developed by newspapers, by medical groups, by county medical societies, by individual physicians, and others.

The practice of medicine represents a division of labor in the general economic system. It has for its object the protection of public health. Although it has become a fairly distinct entity as compared with other members of the economic order, it always has been more or less influenced by those factors which influence all branches of general economics. It has been charged that the medical profession should perfect some method by which the people of the country can secure at all times adequate medical service regardless of their ability to pay. To make such a charge is both unfair and unreasonable. The medical profession of the United States consists of about 15/10000 of the entire population. The medical profession has practically no controlling influence over employment, industry, marketing, business, banking, the value of foreign credits and other general economic factors, all of which influence the degree to which the population in general has the ability to buy medical service.

Medical practice, as the general economic trends change, will undoubtedly undergo some change, but it is necessary for county medical societies to decide whether a change in medical practice is necessary in their respective communities. Change, for the sole reason of practicing medicine in a different way, is never worthy.

The type of medical practice which is to evolve from the present situation lies very largely, if not entirely, in the hands of the medical profession. It is not enough for medical men to read articles, to go to organization meetings and hear talks, and then to return to their homes and say or do nothing more about it. The future of medicine lies within the hands of every physician. It is not alone the responsibility of the American Medical Association; it is not alone the responsibility of the officers of your State Association; it is not alone the responsibility of your county organizations. It is the responsibility of every member of organized medicine to know the trends in medicine today, to know tendencies toward contract practice, toward health insurance, and toward every other method which has for its object the exploitation of both the public and the profession for the profit of lay promoters and lay organizations.

In times of economic stress there is always a demand for change. Whether this demand is made of the medical profession or of other members of the economic order the question should always be asked whether the change that is demanded will bring to the organization, or to the public, advan-

tages that are greater than those which the change supplants.

Before accepting any of the new systems of medical practice a careful examination of the schemes is necessary. Are these new systems of medical practice better for the public, and the individual, than the type of medicine which is being practiced today? Is the medical profession, in accepting a change, lowering its standards of quality of care? Are the proposed changes based primarily upon financial or economic distress, or are they based upon better service to the sick individual? Will the newer types of medical practice result in a more unified and coherent medical organization, and are these new types of medical practice to be controlled by the medical profession? Unless these questions can be answered satisfactorily for the good of the public, the profession is not justified in endorsing or entering upon any particular new plan.

The hope of solving the present problem of medical care lies first, in carefully planned and exhaustive studies, conducted without prejudice and without preconceived ideas, or bias of any kind. It is necessary that every physician participate in this work to some extent. Not until facts are available upon which it can act intelligently is the medical profession justified in admitting that a change in medical practice is necessary.

DISCUSSION

JOSEPH H. WEINSTEIN, M. D. (Terre Haute): It seems rather foolhardy for me to attempt to add anything to what Dr. Leland has said, when we consider the facilities they have at hand in the American Medical Association for ascertaining all of the facts. They are in immediate and complete touch with the Committee on the Cost of Medical Care, and, of course, Dr. Leland has in mind all of these facts about which he has been talking this afternoon.

His entire address naturally led up to the question of so-called state medicine. I think our association as a unit should be behind the American Medical Association in not admitting that there is any such thing. The question of its inevitability we must decide in our own minds; but until that inevitability arises, we, as a medical profession, must not admit that such a thing is possible.

Dr. Leland spoke of the different types of service that may be given. I think he left out one very important one; he left out "thumbing," and that is what a great majority of people are trying to do today—"thumb" their way and escape paying cash fare.

A rather humorous occurrence came to me when the doctor spoke of the five senses of the early practitioners. That is not entirely lost today. It came to me with a great deal of force when I was in camp at Houston. We were having a great many cases of meningitis in the camp, and one typical Texan doctor, a big six-footer, apparently was able to make a diagnosis earlier than most of the rest of us. Our colonel asked him one day, "Captain, tell us how it is that you are able to make a diagnosis of these cases before the rest of us?" The captain got up in an awkward way and said, "Well, Colonel, they smell just like a wet gray horse." He was perfectly honest—there was some smell that he evidently got that escaped the rest of us. Many of the old practitioners were able to diagnose some of the exanthemata, and other diseases, by the smell.

I think that, after all, this whole problem has been brought about through propaganda by the laity in articles in journals and magazines on the cost of sickness. As an example I would refer to an article appearing in the *Atlantic Monthly* in which some man said, "More and better medical service we must have; either it will be voluntary or co-operative, or it will be compulsory. Individualism has had its day." That, to my mind, expresses the attitude of a great many laymen.

Dr. Leland also spoke of the changes coming in a depression. That is true, but the question comes to my mind whether the demand for change has not been brought about by a period of good times. For example: The Columbia unit in New York was not built during times of depression; the Cornell unit was not built during a depression, and I think these two units have done more toward the socializing of medicine in New York City than any other thing that has occurred. Great philanthropies are not started in times of depression. Depressions only bring the ideas of the people more and more to gratuities and especially gratuitous medical care.

The problem for us as physicians is the education of the people. As Dr. Leland said, our main desire is the best medical care that may be given to the people, irrespective of what the ultimate effect upon the medical profession *per se* may be. Publicity through our own publicity bureau is doing a great deal and will do more.

The great thing, as I see it now, the thing that looks more discouraging than anything else, is that practically every move, every condition that has preceded social insurance and state medicine in other countries, has taken place in this country. It has been a matter of history that many of the things that originated in the Old Country years and years ago are being adopted in this country. You get many reports of physicians who are satisfied with conditions, and many reports of those who are dissatisfied; and the same is true of the laymen. Probably the most satisfactory conditions are in Great Britain—the policy laid down by the British Medical Association; but as the secretary of the association says, the greatest fear he has is the interference of the politicians. Against such a crisis, the greatest care must be exercised to see that we, as physicians, have control of the medical end of the entire proposition, that so far as it is humanly possible it must be made so air-tight that the politicians cannot get their fingers into it.

DIVERTICULOSIS OF THE COLON

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Diverticulosis of the colon may be conveniently classed into two groups, namely, congenital and acquired.

The congenital type may be the result of (1) faulty fusion of the segments of the colon; (2) abnormally large openings where blood vessels enter the bowels; (3) and weak musculature of the bowel wall. It is not unusual to find the mucosa herniating through these openings above described and causing a distinct pouch or diverticulum protruding on the outside of the bowel wall.

The acquired type may arise from bowel ulceration, gas pressure, heavy lifting, and crushing injuries.

Any of the above factors or any combination of the above stated conditions contribute to diverticulosis.

The relative incidence of the above pathology dominates in the male over the female in a ratio

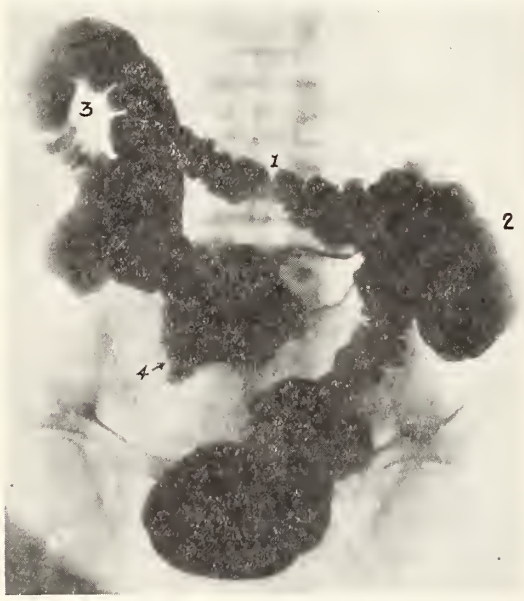


Fig. 1—1. Sigmoid displaced to right.
2. Cecum.
3. Splenic flexure.
4. Large ulcerative diverticulum of transverse colon.

of two to one. These statistics would have to be based on those cases of diverticulosis which have been demonstrated and which show symptoms. Without doubt numerous cases which show no symptoms have never been discovered. The male is subject to more violence, such as injury, heavy lifting, and crushing. This would account for injury to diverticula which have previously never shown symptoms. Lifting heavy loads when the bowel is loaded with hard fecal masses may cause spreading of the muscularis with subsequent herniation of the mucosa through the bowel wall, or it may cause a rupture of a diverticulum which was already present.

Diverticula occur in the sigmoid more frequently than in any other part of the colon at a ratio of about three to one. The descending colon and the sigmoid show about four-fifths of the diverticula

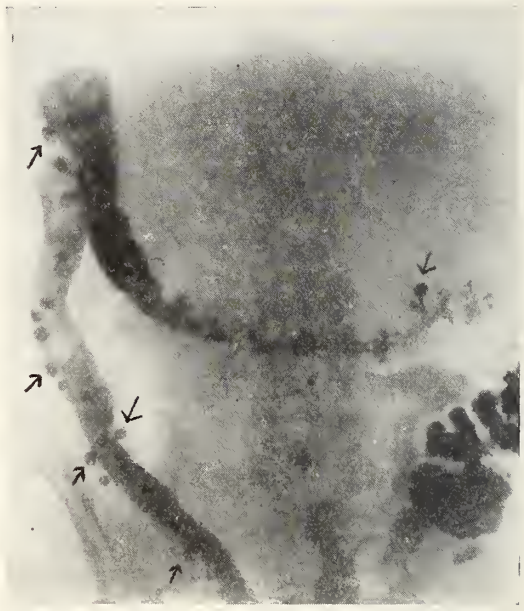


Fig. 2. Colon filled by enema demonstrating extra lumen shadows.

demonstrated in the colonic tract. This fact corresponds with the idea that hard masses may injure the colon wall. It is very evident that most of the hard masses contained in the colon are present in the descending and sigmoid.

There is no typical chain of symptoms which present themselves. The patient usually complains of a sense of weight or pressure in the upper abdomen, which is relieved by passing gas. There may be pain in the region of the diverticulum if there is local peritonitis. Many times there is a feeling of a lump in the midepigastrium which is usually a reflex referred to the superior mesenteric ganglion. This latter symptom probably arises when there is hyper-peristalsis of the gastrointestinal tract in the region of the diverticulum.

Involvement of the peritoneum causes symptoms to be transmitted to the superior mesenteric plexus with subsequent reflexes in the somatic structures corresponding to the area involved.

If ulceration occurs, blood may be present in the stool; however, blood is not a constant symptom of diverticulosis. Red blood may occur in the stool if the ulceration is low in the colon; however, tarry stools may be present regardless of the position of the lesion, if the blood is retained over a sufficient interval.

One patient gave an ulcer history, in that she always had pain when the stomach was empty.

Her symptoms and attacks came up about the time when peristalsis was active in the colon. Any factors that decreased or increased colon peristalsis would decrease or increase pain in the same proportion.

Acute crises of pain may arise which simulate gall bladder, renal or appendiceal colic. In fact, any symptom may be simulated that has back of it clonic or tonic spasm.



Fig. 3. Enema given after 24-hour observation, showing numerous diverticula from cecum to sigmoid.

Diverticula occur in all numbers, positions and sizes. One case in which the number was counted showed 128 distinct, rounded, extra lumen shadows. The diverticula were distributed from cecum to sigmoid. The larger shadows were in the cecum; however, there was not a segment of the colon which was free of the pathological process.

Many times diverticula are demonstrated which cannot be connected in any way to the patient's symptoms. They may be in any position and vary in size from one inch in diameter down to a small pea.

Symptoms are not dependable because of the great variety of distribution. The symptoms may be local when the peritoneum is involved and may be reflex when impulses are projected to the somatic structures.

We must depend on x-ray examination to demonstrate the extra lumen shadows. An enema is usually employed following a barium meal which may have been given 24 or 48 hours previously.

After a meal has been given, its slow progress through the bowel will fill the diverticula with barium. After the extra lumen pouches have been filled the enema will demonstrate the position of the shadows outside the bowel wall.

My barium meal contains plenty of powdered acacia which prevents hard masses from forming in the haustra. Its consistency always remains pliable and smooth and is easily moulded to any contour of the bowel folds. This meal has been checked against the usual buttermilk meal and has been found to be more dependable in showing diverticula.

PROGNOSIS: Diverticulitis presents the most serious aspect of diverticulosis because of the disposition to cause focal peritonitis or perforation of the bowel. The prognosis to the patient is very important; it is, therefore, imperative to know if you are dealing with peritonitis. Treatment of the condition cannot be of very great choice. If there is peritonitis with perforation complicating the field, surgery should be employed. If, however, the involvement includes the whole colon, medical treatment must be used because of the attending dangers of colectomy. Therefore, the extent of the lesion must be considered and metastatic foci should be sought to determine differentiation between benign and malignant involvement.

NEOARSPHENAMINE IN TULAREMIA

(CASE REPORTS)

W. S. FISHER, M. D.
COLUMBUS

Tularemia is sufficiently common, especially in the rural communities, to warrant some notice. A great deal has been written recently on this subject, but very little, if anything, has been said about treatment. The Staff Proceedings of the Mayo Clinic, October, 1932, concludes an article on tularemia with the following statement: "So far as we are aware there is no specific treatment for tularemia." Sajous' most recent volume, published in 1931, does not mention treatment. Probably there has not been enough investigation, as yet, to decide upon a specific treatment. However, I believe that the profession should know that neoarsphenamine is being used successfully. This is not a new treatment, nor do I claim priority for it. I happened, in 1930, to give it to a patient suffering with tularemia because I thought he had syphilis. His response was very satisfactory. I have successfully treated two more patients in the same manner. I also know that another case in this community was likewise very satisfactorily treated.

The initial dose ordinarily employed is 0.45 gm. The injection is repeated in five to seven days using 0.6 gm. In a few instances the third dose is increased to 0.75 gm. It has not been necessary to give more than five doses. The primary lesion responds to treatment exactly in the same manner as the primary lesion of syphilis. The primary lesion of tularemia soon reaches a greater depth and size than the primary lesion of syphilis and for this reason the healing requires just a little

longer time. The pain and swelling at the site of the primary lesion and the accompanying member begin to disappear after the first injection. Tenderness is likely to persist for some time after healing has taken place. The improvement in the general condition of the patient, increase of appetite, and loss of temperature, are just as satisfactory as the improvement in the primary lesion. Two patients experienced an improvement in their sense of well being almost immediately after each treatment. Another who had been bedfast for several weeks and received the first treatment early in the afternoon insisted on sitting up to listen to a radio program the same evening. The primary lesions are dressed with 10 per cent ammoniated mercury ointment until they are clean and dry, then dry dressings are applied.

Case Reports

Mr. C. T., 50 years of age, had been sick two weeks. He had a punched-out ulcer on the dorsum of the left thumb about one centimeter in diameter. The thumb was swollen and there was a generalized adenitis, particularly left epitrochlear and left axillary. His temperature was about 103. He was listless and drowsy and content to lie around. He did not appear to be very ill and I was surprised to find his temperature so high. He gave a history of having dressed some rabbits a few days before he noticed the lesion on his hand. There were white patches in his throat. Smears from these did not show any diphtheritic or Vincent's infection. There was a loss of appetite. He had lost some weight. Outside of the adenitis and primary lesion the illness resembled beginning typhoid fever. He received 0.45 gm. of neoarsphenamine for the first dose, five days later 0.6 gm., and five days after that 0.75 gm. of neoarsphenamine. The wound healed rapidly. The patient was able to be up and soon regained his weight and strength.

Mr. R. Y., a man about forty years old, came in with the following history: Two days previous to the onset of his symptoms he had been hunting and dressed fifteen rabbits. His initial symptoms were those of a severe attack of la grippe: chills, aching, fever, and a general malaise. He noticed on the index finger of his left hand a white blister about one centimeter in diameter which he opened with a sterile needle, but nothing came out. The finger became swollen and he developed a left epitrochlear and left axillary adenitis. He saw me after the initial rise of fever had subsided, during the period of remission. His temperature was 100. In the absence of other findings the clinical diagnosis of tularemia was made. Blood was sent to the laboratory for the agglutination test which was negative. Treatment was withheld for one week. At the end of this time the symptoms had all progressed, temperature had returned, the blister had become a punched-out ulcer, and adenitis had increased. Another blood test was taken and at the same time 0.45 gm. of neoarsphenamine was given intravenously. The second blood specimen showed a positive agglutination 1-160 for tularemia. This man received three more injections. The last was perhaps unnecessary, as practically all the symptoms had disappeared after the third treatment.

Mrs. H. B. took sick two days after she dressed a rabbit. Her first symptoms were those of influenza. A week later it was thought she had blood poisoning. She had been sick two weeks when I saw her. She had two large punched-out ulcers on her left finger and left hand with considerable swelling, pain and tenderness and a generalized adenitis. She had lost weight, had a temperature of 100.5 and felt very badly. The blood serum showed agglutination up to 1-120 for tularemia. Wassermann was negative. She was given four doses of neoarsphenamine, ranging from 0.45 to 0.6 gm. The fourth and last treatment was probably unnecessary, for, as in the other cases, the primary lesion healed promptly, the fever subsided, appetite returned and the patient was able to resume her work.

There has never been any return of symptoms or ill effects in any of these cases so far as I know.

Summary

Three cases in my practice have responded promptly and satisfactorily to three or four injections of neoarsphenamine. I know of another case in this town and have heard of others, likewise, treated with success.

This is also a practical method of treatment because nearly every physician has the equipment and is familiar with the technique of administering neoarsphenamine.

UNUSUAL DISLOCATION OF PATELLA*

JOSEPH R. BLOOMER, M. D.
ROCKVILLE, IND.

I am reporting the following case because of its unusual features, so unusual that the facts, as reported by me, have been doubted by authoritative physicians. The facts in this case are no more unusual than the case of the man with the iron bar driven through his head.

Mr. S. K., age 53, coal miner, became entangled in vines on Sunday afternoon and fell, hyperextending his left knee. There was very little pain, but when he arose his left knee was stiff and any attempt to flex it was accompanied with great pain. He reported at my office the following morning. He said he had always had slight rheumatism in both knees, but had had no previous injury.

Inspection showed no abnormality, no swelling, discoloration, or deformity. Palpation revealed

* Reported before Parke-Vermillion County Medical Society, August 17, 1932.

the patella displaced upward in the median line and firmly fixed, with an abnormal depression just below. There was no pain on pressure anywhere about the knee, but any attempt to move the patella or flex the knee was accompanied by severe pain. The knee was x-rayed, with the result as shown in the accompanying photograph. It showed the patella displaced upward so that the lower border was firmly lodged against an exostosis on the



Fig. 1.—X-ray of Knee

anterior surface of the lateral condyle of the femur. The patella itself showed exostoses at both the upper and lower ends. Other arthritic processes were visible on other surfaces of the femur and tibia.

He was relaxed by general anesthesia, the knee hyperextended, at the same time upward traction was made on the patella and the upper margin depressed when the patella slipped back into place. I saw no reason to apply splints as there was no fracture. A simple bandage was applied, and he was told to rest the leg for several days. The patient did not report to me as directed, and, upon inquiring, he told me the leg felt so good, not giving any pain or inconvenience, that he had returned to work in the mine on the next morning after the reduction of the patella, and has continued with his regular work ever since.

Examination reveals the left knee as normal as the right. Why there was no rupture of ligaments, no swelling nor disability following the injury, I cannot explain. Without the x-ray I would have doubted the diagnosis; but with the x-ray, the manipulation for reduction and the immediate complete recovery, there can be no controversion.

OBSERVATIONS ON THE USE OF K MEDIUM IN BLOOD CULTURES AND BACTERIAL CULTURE OF HUMAN TISSUE*

F. W. TAYLOR, M. D.
INDIANAPOLIS

Kendall's observations[1] of his studies in filter passing bacteria and his K media for culturing these forms suggested many interesting bacteriological problems. Among those most interesting to us was the possibility of demonstrating bacteria in the blood stream of acute surgical cases with some degree of constancy. Undoubtedly large numbers of bacteria are poured into the blood in such cases as acute appendicitis or acute cholecystitis and yet in these patients it is seldom that a positive blood culture can be obtained from the peripheral blood. It was thought that possibly these organisms, in a filter-passing state, do pass through the capillary network of the lungs and extremities, but were not found in the peripheral blood because they could not be cultured by routine laboratory methods. It was in the hope of obtaining positive blood cultures in these cases by means of K medium that the following study was attempted.

As will be seen, our efforts along this line failed, and the following brief account is given as a negative report. It does not indicate that bacteria are not present in the peripheral circulating blood of such cases as have been studied but merely that our present laboratory procedure is inadequate to demonstrate them. No advantage could be found in the use of K medium over the usual dextrose heart infusion medium used routinely in blood culture work. A larger proportion of contaminations found in the normal well patients would seem to be due to poor sterilization of the skin at time of withdrawing blood. The number of cases studied is small but as the results of the investigation were uniformly negative there seemed little purpose in continuing them.

Closely related to the above study was an attempt to demonstrate pathogenic organisms in the filtrable or non-filtrable form in normal human body tissues. Fat, fascia and muscle obtained from the abdominal wall of "clean" surgical cases were used. This culture work was discontinued because practically all the tissue obtained at operation was contaminated by some air-borne organism. It seemed useless to proceed in the face of this constant contamination without the adoption of a technique far more scrupulous than that used in the operating room. The results of this study are briefly given.

I. *Technique, blood cultures.*

(A) Preparation of skin on normal well patients:

Alcohol and iodine.

* Department of Pathology, Indiana University School of Medicine, September, 1932.

(B) Preparation of skin on acute surgical cases:

Half were prepared with alcohol and iodine. On the remaining half a green soap scrub was used followed by a bichloride wet dressing for eight hours. Skin was painted with iodine just before taking blood culture. Using this latter method there were no culture contaminations in twelve consecutive blood cultures.

Ten c.c. of blood was taken from the anticubital vein into an autoclaved syringe and immediately ejected into 90 c.c. of the media previously warmed to approximately 38°C. Media consisted of dextrose heart infusion and K medium.

The dextrose heart infusion was adjusted to a pH of 7.6. The K medium used was made from the powdered extract prepared by Digestive Ferments Company under the direction of Dr. Kendall. Three grams of this powder were suspended in 100 c.c. of water and autoclaved at 15 pounds for twenty minutes. The pH of this medium varied from 7.2 to 7.4.

Incubation was carried out at varying temperatures ranging from 30°C. to 37.5°C. As all growths were those of the contaminants, it cannot be claimed that temperatures in this range made any difference with specific growths.

Sub-cultures were attempted every two or three days for the first week and after that every six or seven days.

All surgical blood cultures were taken one to three days postoperatively.

II. *Bacterial Culture of Human Tissue.*

Following the usual surgical skin preparation pieces of fat, fascia and muscle weighing 10-15 grams were removed from the abdominal wall. A second set of instruments were used in this procedure to reduce chance of skin contamination. Tissue was dropped into petri plates from where it was shortly transferred to flask of media. Media consisted of dextrose heart infusion and K medium. All patients were "clean" surgical cases (herniotomy, uterine suspension, etc.).

RESULTS OF BLOOD CULTURES

I. *Normal Patients.*

(A) Five blood cultures using dextrose heart infusion medium with no growth or contamination (carried eight weeks).

(B) Five blood cultures using K medium.
- 2 cultures, no growth (carried eight weeks).
- 1 culture, Mycoides after two days.
- 1 culture, Sarcina citria after two days.
- 1 culture contaminated with B. subtilis after sub-culturing for two weeks.

II. *Postoperative Blood Cultures on Contaminated Surgical Cases (Ruptured Appendices, Acute Appendices, Chronic Cholecystitis, Suppurative phlebitis).*

(A) Twelve cultures using dextrose heart infusion (carried ten weeks). There was no growth in any of the cultures except for one flask. This was from a case of acute appendicitis. The growth was identified as Bacillus lantus and considered a contaminant.

(B) Twelve cultures using K medium (carried ten weeks). All were negative except for one flask in which Bacillus subtilis was a contaminant.

RESULTS OF ATTEMPTS TO DEMONSTRATE BACTERIA IN NORMAL HUMAN TISSUE

Of six such attempts with tissue taken from the abdominal wall as previously indicated, five contaminant growths were obtained. One flask remained sterile for six weeks. The contaminants were Stapylococcus albus, Micrococcus auranticus, Staphylococcus tetragenous and Acromobacter raveneli. These growths were thought to have had their origin from the air of the operating room or from the patient's skin.

The operative wounds of these cases all healed promptly by primary intention showing that the bacterial contamination which was present was easily overcome by the normal body repair. No organisms were demonstrated which could be interpreted as any but air borne contamination.

COMMENT

(1) Attempts were made in this study to demonstrate pyogenic organisms in the peripheral blood stream of routine acute surgical cases. This failed using the usual laboratory media and also K medium. It is impossible to say whether this failure was due to present inadequate laboratory methods or due to the fact that organisms which are picked up from infected foci are filtered out in capillary beds before reaching the peripheral blood.

(2) Several attempts were made to culture bacteria from normal human fat, muscle and fascia taken at the time of operation from "clean" cases. This study was discontinued because of the practically constant contamination of such tissue by air borne organisms. Before any such investigation can be carried out it will be necessary to use an aseptic technique which is far more rigid than that in use in the ordinary operating room.

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JUNE, 1933

EDITORIALS

GRANULOCYTOPENIA

In the daily press, with ever increasing frequency, we read of the "peculiar dread malady" which, with lightning rapidity, snatches its victim from the well-meaning but helpless hands of medical attendants. The mysterious nature of the ailment is stressed, and the futility of therapeutic measures made all too apparent. In spite of our knowledge that the "Grim Reaper" is always ultimately the victor in this scheme of things, the challenge remains paramount, and the forbearance and perseverance of medical science will conquer the black magic of agranulocytic angina, as it has vanquished, to a great extent, the onslaughts of malaria, typhoid, diphtheria, tetanus, scarlet fever, smallpox, and a host of other formidable and ever threatening enemies to the preservation of life and health.

As is usual in the case of a comparatively rare condition, many descriptive terms have been employed by various authors, since the condition was described in detail and given a name by Schultz in 1922. There is, however, undoubted evidence in the literature to support the existence of the malady long before this time. Senator in 1888, Brown in 1902, Turk in 1907, Baldridge and Needles in 1910, and Larson and Barron in 1913, have described cases which leave little doubt as to their proper classification under this group. Since the classical description of Schultz, the disease has been variously termed "angina agranulocytica" by Friedmann, "malignant neutropenia" by Schilling, "sepsis with granulocytopenia" by David, "mucositis necroticans agranulocytica" by Weiss, and "granulocytopenia" editorially in the *Journal of the American Medical Association*. Since the latter term is descriptive of the variation in the number and percentage of white blood cells affected, it should be preferred, reserving the term agranulocytic angina for those cases, which in addition to the blood changes, show characteristic oral lesions. This distinction, however arbitrary, has the factor of established usage in its favor.

The condition, as described by Schultz and many others, has as its characteristic picture, necrotic lesions involving the pharnyx, tongue, mouth, and at times vagina and rectum; fever and marked prostration; and rapid diminution of the granular cells from the peripheral blood stream. Until the report of Jackson, Parker, and Taylor, it was considered fatal in about ninety per cent of the cases. Their report of seventy per cent recoveries in 54 cases has not been approached by any other published series.

Etiologically the condition remains shrouded in mystery. Seventy-five per cent of the cases occur in women between the fourth and sixth decade. Poisoning from heavy metals, bacterial toxins, unusual foods, cosmetics, drugs, hair dyes, mouth washes, oral sepsis, Vincent's angina and benzene poisoning, are but a few of the possible causative factors advanced. No class or variety of occupation has been exempt, and it is frequently seen in the well-to-do. Practically every variety of organism has been isolated from the lesions, and many have been recovered from the blood stream. Pathological descriptions of the changes present have failed to point the way to the causative agent, or to suggest suitable and effective therapy.

The diagnosis reveals itself in the acute septic condition with marked prostration and fever; a lowered white blood cell count with the polymorphonuclears greatly diminished or absent and the remaining blood elements relatively normal; necrosing, ulcerating lesions involving the mouth, pharynx, and frequently the genital and intestinal tract.

In the field of therapy we find a host of remedial agents, which have for the most part been ineffective. Locally such antiseptics as tincture of iodine, mercurochrome, alcohol, arsphenamine, silver nitrate, iodoform, metaphen and actual cauterization have failed to stem the course of the disease. Intravenously such therapy as the administration of whole blood, autogenous and stock vaccines, antistreptococcus serum, diphtheria antitoxin and nonspecific proteins have been tried without results. Nucleinic acid injections, and the use of adenine sulphate have been effective in some reported cases in conjunction with other measures. The value of repeated blood transfusions is stressed. The use of transfused blood from recovered cases has shown favorable results, but obviously the securing of such a donor is indeed rare. Stimulating doses of x-rays to the long bones is widely recommended in favoring production of the granular cells by the bone marrow. The use of colloidal sulphur for its leucocytic stimulating value has

been advanced, as has the production of sterile abscesses with turpentine. Liver extract therapy may be of some use in conjunction with other measures.

The report of Jackson, Parker, and Taylor of their results in 54 cases, through the use of intravenous and intramuscular injections of pentose nucleotide K96 is extremely interesting, and should stimulate its use and observation in a larger series of cases. Such a substance, capable of stimulating the bone marrow, without damage to the tissues, has long been the goal of therapy in this malignant disease. It is to be hoped that their reported success may further stimulate the production of a specific remedy.

OPHTHALMIA NEONATORUM

Morris Fishbein, in an editorial,* has somewhat to say regarding the signing of the compulsory prophylaxis measure by Governor Horner. It seems that a similar bill was enacted by the Illinois legislature, about a year ago, but was vetoed by the governor in office, Louis Emmerson. It was generally understood that the veto was due to inordinate pressure by the Christian Scientists, together with the fact that the attorney general had declared the act unconstitutional.

It is a fact that the so-called police power usually accorded to various states is much narrower in Illinois than in other states. It is a moot point just how far that state may go in matters of even so great importance as public health. It will be interesting to know the fate of the bill, for an attack on it seems certain.

Indiana is more fortunate, in that we have had a similar law for many years. That the legislation has proved effective is evidenced by the diminishing cases of blindness due to this condition. We recall, some twenty or more years ago, having eight such cases in the practice of one physician in a period of less than six months. His explanation, when taken to task in the matter, was that he "forgot!"

The late Dr. George F. Keiper, of Lafayette, labored long and arduously to bring about the enactment of the law. We recall the meeting, at Fort Wayne, when he finally succeeded in getting through the House of Delegates a resolution demanding such legislation. Nor was this accomplished without much trouble for at that time we had many physicians in our membership who were doggedly opposed to such "interference" with their affairs. It was the following year, we believe, that the bill successfully ran the legislative gauntlet, not all the opposition coming from laymen.

Prior to this time it was generally conceded that one-third of the inmates in our School for the Blind were there because of this form of eye infection. We have not the present figures at hand, but from our personal observation and from reports from other states we have no doubt but that blindness from this cause, in Indiana, is exceedingly rare.

It is inconceivable that any person or any organization would conscientiously oppose such a simple prophylactic procedure as the Credé method of guarding against infection of the eyes of the new born; it is an entirely harmless thing, is generally effective, and has greatly reduced blindness following birth-canal infection.

Our profession must assume part of the blame for the continued opposition of certain groups to the "prophylactic drops." Just as in smallpox vaccination, typhoid vaccination, diphtheria immunization, and all the host of other immunizing agents, we, having accepted them ourselves, are too prone to stop right there; we have not attempted to publicize these things to the extent that they merit. We believe we have had more and quicker success with diphtheria immunization than with some of the older prophylactic methods, solely due to the fact that this has had greater publicity; it is more spectacular, if we may use such a term in this connection; it has a most direct appeal to the mothers, for we must concede that it is the mother who is most interested in guarding her chicks.

It is true that we are spending more time and more money, each year, in propaganda; the general public is becoming more and more health-conscious as time goes on; the general public is more and more interested in prophylaxis, in hygiene and in sanitation. But we must carry on to even a greater degree; we must "sell" immunization, prophylaxis, and all that sort of thing, even though we have to resort to high-pressure salesmanship. It is possible to educate the laity to the point where little or no opposition to remedial and prophylactic measures of any sort will exist.

ANIMAL EXPERIMENTATION

Many of the troubles of the world are due to ignorance and stupidity. For ignorance one can feel pity, but for stupidity and wilful obstructiveness no consideration seems necessary. Of all the people who seem stupid or wilfully stupid to the medical investigator, those who class themselves as organized "antivivisectionists" are the worst.

Almost all of the victories won over disease and death by medical discoveries of recent years have been made directly or indirectly possible by the use of lower animals. The future progress of surgery, medicine and public health still depends upon the continued use of lower animals. By means of animal experimentation have been discovered the cause and means to control such scourges as tuberculosis, smallpox, bubonic plague, diphtheria, surgical sepsis, childbed fever, typhoid fever, cholera, syphilis and general paresis, diabetes, and pernicious anaemia.

At the time of the beginning of the activities

* J. A. M. A., April 29, 1933.

of the antivivisectionists fifty years ago their contention was that the use of lower animals was futile. With the massing of such evident benefits to mankind this argument of futility has had to be changed by them. They now say that, even admitting there have been values, these values have been gained by cruelty to the animals. Their claim is that the animals have rights which must be respected notwithstanding their service to mankind. They contend that, if knowledge can be obtained only by means of the experimental use of lower animals, human beings should suffer unless some other means can be found.

It has been asked,[1] "Who are these antivivisectionists that one should respect their opinion as to what should and what should not be done to save human life?" They are mostly childless, elderly women with a perverted mother-sense; a few—in the main publicity-seeking—clergymen, writers, actors and business men, perhaps occasionally sincere and well-intentioned, but nevertheless grossly ignorant and stupid; and of course, for ulterior motives, the representatives of Christian Science and of the cults. There occasionally are individuals who for real or imaginary reasons feel that the medical profession or one of its members has not dealt justly with them. There also are a few renegade "doctors" whom notice would otherwise pass by.

There are adequate laws against cruelty to animals. It is the privilege of antivivisectionists to invoke these laws. This use of anticruelty laws has not been made. Since 1921 the investigators and medical schools using animals in research or teaching have had an "open door policy." The doors of laboratories throughout the United States are open to representatives of humane societies, the only condition being that the visitor has seen a surgical operation on a human being in order that he have a basis for judgment of the humaneness of the treatment of the animals. All investigators whose integrity can be accepted have testified that most operations on animals are done by methods making them practically painless, and that in medical schools operations by students are done under anaesthesia from which the animals never awaken.

The benefits of such investigators to the lower animals themselves have been enough to compensate for any service to man. They have been protected by the development, through animal experimentation, of serum against anthrax, swine erysipelas, hog cholera, foot and mouth disease, and rabies.

No group of men can claim greater love and consideration of animals than physicians. The love of any legitimate practitioner of medicine, practically all of whose exact knowledge has been based on animal experimentation, for his horse or dog is not surpassed by any self-styled lover of animals. There is no evidence that his experience with animals in medical school has made him callous and brutal. One has evidence continually of how gladly a dog lays down his life for his master. If he will do it without hesitation in the face of physical violence to his master would he not, if he understood, do it as gladly to protect him from disease? And why "in the name of the seven mad gods that rule the seas," if all injury and destruction of animal life is immoral, have the antivivisectionists concerned themselves with the relatively few animals employed in the laboratories for the relief of the world's suffering when, for sport, hunters slaughter millions of birds and beasts; when in a most cruel manner millions of animals and fowls are killed in abattoirs for food, when in nineteen of our largest cities more than 350,000 cats and dogs are put to death in no gentle manner merely to clear the streets; and when for warmth or merely for the vain adornment of our women, millions of specimens of wild life are caught and killed in the cruelest of traps or by the most cruel poisons? And while they choose to be ridiculous, why does not this antivivisection group start an anti-fly-swatting, or an anti-rat-killing campaign? Is there any evidence that a dog or a cat values its life any more than a fly or a rat?

ARE YOU DELINQUENT?

Dear Doctor:

We are asking you to send your dues to your county medical society secretary TODAY if possible—

BECAUSE the medical profession is facing a real crisis and is battling for its very life;

BECAUSE the profession is being attacked on all sides by theorists and self-styled economists, who want to socialize the practice of medicine;

BECAUSE it is a fact that no matter how capable, well informed, and active you may be, as an individual physician you can accomplish little playing a lone wolf hand, while as an integral part of an active, battling medical organization, such as the Indiana State Medical Association, you can go far;

BECAUSE the Indiana State Medical Association is carrying on this battle for you and if it is to continue its activity along militant, aggressive lines, it must have your support and your membership;

BECAUSE in addition to its regular activities the State Association has taken on a number of new projects which are vital to the medical profession;

BECAUSE ten times as many malpractice suits are being filed today as in normal times; and hence every day you are without membership in the Association you are taking an ever-increasing chance of going defenseless in case a malpractice suit is brought against you;

BECAUSE due to postal mailing regulations we must take your name off of "The Journal" mailing list within the next few months if your dues are not paid; and,

FINALLY, BECAUSE you owe it to yourself, no matter how hard pressed you may be, to be a member of your county, state and the American Medical Associations, and to give organized medicine your support during these strenuous times.

Yours sincerely,
THOMAS A. HENDRICKS,
Executive Secretary.

[1] Cannon, Walter B. Scientific Monthly, Feb., 1933.

We quote Professor John Dewey of Columbia University:

"No one who has faced this can be in doubt as to where the moral right and wrong lie. To prefer the claims of the physical sensations of animals to the prevention of death and the cure of disease —probably the greatest sources of poverty, distress and inefficiency, and certainly the greatest sources of moral suffering—does not rise even to the level of sentimentalism.

"It is accordingly the duty of scientific men," he declares, "to use animal experimentation as an instrument in the promotion of social well-being; *and it is the duty of the general public to protect these men from attacks that hamper their work. It is the duty of the general public to sustain them in their endeavors.* For physicians and scientific men, though having their individual failings and fallibilities like the rest of us, are in this matter acting as ministers and ambassadors of the public good."

THE INDIANA STATE BOARD OF HEALTH

The article concerning the new set-up for the Indiana State Board of Health, outlined in the May number of THE JOURNAL, is well worth the time and attention of every member of the Indiana profession; it is a very informative presentation of a very important subject. This program has the unqualified endorsement of the officers of the Indiana State Medical Association and of a considerable number of its component county societies which have had opportunity to discuss it in the regular meetings.

For many years past there have been serious objections to many of the activities of the former Board, these being chiefly concerned with the laboratory and the Bureau of Infant Hygiene. This latter department was criticised perhaps more often than any other because of the expense involved, and because it was declared to infringe very strongly on the "rights" of the licensed medical men of the state. That the new arrangement will result in a considerable saving may be adduced from the fact that the economies already effected will result in a reduction of something like $85,000 annually and it is hoped to increase this to the sizeable sum of $100,000. We believe this reduction can be made without in any way crippling the activities of the Board.

That there is some lay criticism resulting from the changes made and proposed there is no denying; that the Indiana profession has its work cut out for it, these next few years, also cannot be gainsaid; but we have an abiding faith in our profession; we know of the interest the officers of our State Association have in matters of such importance, hence we feel secure in the belief that once the organization is completed, there will be little room for justifiable criticism.

Many of the duties once carried out by the Board will be relegated to the county societies, and the membership-at-large is expected to give not only moral support, but active personal support. We have no misgivings about the success of the plan; we feel secure in the belief that after a few months the "Indiana Plan" of health control will have found a secure place in the economic scheme of things.

CONCERNING INFANT AND MATERNAL WELFARE

By this time most of the doctors of this state are familiar with the fact that the work of the Division of Infant and Maternal Welfare of the old State Board of Health has been discontinued. We have had many occasions to talk this matter over with the profession and find that in practically every case this change has been most gratifying to the members.

The Division of Infant and Maternal Welfare was costing the State of Indiana approximately $65,000 a year, which in this time of economic stress is no small sum. That is, however, a small matter if the division had done what it was supposed to be doing. Most of us have wives and children, and we are willing to make any sacrifice in their behalf. We believe, however, that such work as this division was doing can be better done under the new plan, whereby the Department of Health will determine the general direction and give aid when aid is needed. By the present arrangement, the organized medical profession, the University Medical School and the State Department of Health are going to work together through the local medical profession to accomplish these purposes. We should like to call attention to the fact that the doctors of the state now have the ball. It is up to them, and we are anxiously waiting to see whether they are going to play the game or merely stall. We should like to remind them that stalling is not a popular style of play in Indiana and that stalling does not make scores.

The layman is much interested in matters pertaining to health. He is particularly interested in matters pertaining to women and children. He is demanding instruction in health. He expects campaigns, demonstrations, and clinics. He feels that he is paying for them, and he is going to get them. The question is, will the medical profession serve this need, or will it sit tight until someone takes the ball away from it? The writer of this editorial is highly enthusiastic about the present plan, provided the medical profession will get busy and discharge its obligations in this respect. He has already taken three or four "socks on the chin" while attempting to defend the present set-up, and expects to receive others. He is in a position to *know* that the public is going to support this move if it is worthy of support, and if the profession will get busy and do the work laid out for it.

There is great need for such work at the present time, inasmuch as many children are on the verge of malnutrition and thousands of women and children are in need of medical, dental, and nursing care for the reason that the state of their finances makes it embarrassing to consult the physician, dentist, or nurse, when they cannot pay the usual fee. These are grim times, and the public is in no mood to sit by and permit work of this nature to fall to the ground. Here is the opportunity for which we have been clamoring. Unless the responsibility is accepted it will be necessary to make some other plan or return to the old one. We simply wish to remind the members that every one *must* help—every one must be willing "to fish or cut bait."

THE DOCTOR'S FEE

An interesting court hearing was had down in Evansville recently, involving the amount charged by a local physician in attending a rather well-to-do patient during her last illness; newspaper reports indicated the claim was $5,000, which of course is a sizeable sum as fees go nowadays. The question at issue before the probate court brought out some sharp debate between those immediately concerned.

The attorney for the defense made plain their case when he asked the doctor who had filed the claim, "Isn't this charge for treating Mrs. Blank the direct result of a recent decision of physicians to boost their charges because lawyers are getting so much in fees from estates, and they want their share?" The reply was to the effect that "That has been talked about by doctors here and we know lawyers overcharge."

The doctor's contention that the claim was not excessive was supported by several of his confreres, one of them the president of the local medical society. We have not learned as to the outcome of the case, but it brings up many points worthy of our consideration.

Lawyers, generally, seem to have very flexible fees; it seems apparent that they cut the cloth to fit the individual case. It is also apparent that at least two considerations enter into the making of the fee, the ability of the client to pay and the mental state of said client. If the chap is in a real jam, the tariff goes up, plenty. Again, in certain instances, the fee is fixed according to the amount involved, this being especially true in foreclosure cases; the amount of work involved and the number of court appearances is the same, no matter whether the amount involved is one thousand or a hundred thousand dollars; but the fee is a different question, a horse of an entirely different color and frame of mind. Whether there is more dignity attached to the foreclosure of a large property as compared to a small one we do not know, but we do know, and this from personal experiences, that the aforementioned tariff increases according to the value of the property. One attorney remarked to the writer that in a period of less than two years he had accumulated fees of some $45,000 from foreclosure; this of course was not cash, but now stands as judgments against the various properties.

Some time ago a prominent local attorney occupied considerable space in a newspaper with what amounted to a tirade against the medical society in this region, because we dared oppose a sales tax, in the form in which it had been introduced; he ranted about the duty of the profession in times of present stress; he made an almost convincing plea that the legal profession was taking its full share of the present burden. A short time later the receiver of our largest bank made a final report of his activities (he had resigned his post), and in that report took occasion to remark that during the year he held the position *twelve per cent of the money he had collected had been paid out for attorneys' fees!* All of which would seem to controvert the notion that the local legal profession was entirely altruistic.

Some time ago we were "invited" to go to Chicago, there to testify in a suit against the United States; we were assured that we would be paid at once and were told that the fee would be the munificent sum of fifteen dollars, cash in hand. A little inquiry served to bring out the information that our testimony was of vital importance and that if the suit were successful the attorney in charge would receive some two thousand dollars. Write your own label to that one.

We cannot deny that some medical men, to use a charitable expression, are a bit careless in the matter of medical fees at times; we know of numerous instances in which the fee might well be considered as entirely out of proportion; but we do feel that our legal friends too often take exception to the charges made for our professional services. A man will employ an attorney to fight the collection of a legitimate fee, then turn right around and pay the lawyer considerably more than the amount involved. It would be very interesting to know what fee was charged by the attorneys who opposed the collection of the bill presented by the Evansville physician; also the amount allowed by the court as attorneys' fees for handling the matter in probate court.

THREE ITEMS FOR YOUR ATTENTION

1. Dues. Please read the notice centered on page 279.

2. Indiana University Postgraduate Course. Read the two page announcement on page 304 and advertising page xv in this issue.

3. Liquor prescribing regulations. Latest interpretation of the rulings effective after May fifteenth will be found on page 287.

EDITORIAL NOTES

DEAR DOCTOR:

THE JOURNAL and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital.

We invite and urge you to use this Service.

It is absolutely *free* to you.

The Cooperative Bureau is equipped with catalogues and price lists of manufacturers, and can supply you information by return mail.

Perhaps you want a certain kind of instrument which is not advertised in THE JOURNAL, and do not know where to secure it; or do not know where to obtain some automobile supplies you need. This Service Bureau will give you the information.

Whenever possible, the goods will be advertised in our pages; but if they are not, we urge you to ask THE JOURNAL about them, or write direct to the Cooperative Medical Advertising Bureau, 535 N. Dearborn St., Chicago, Illinois.

We want THE JOURNAL to serve *you*.

Such, so it seems, is Life! Just when we discover a county secretary who injects a bit of pep and ginger into his bulletins, penning a few up-to-the-minute quips, some other journal appropriates our find. Now we shall have to cast about for a new source of inspiration.

RAILROAD rates to the Milwaukee session of the American Medical Association, over the Chicago, Milwaukee, St. Paul and Pacific Railroad, have been reduced to one and one-third for round-trip, instead of the one and one-half fare charged in former years. Round trip fare from Indianapolis to Milwaukee will be $12.97.

THE *West Virginia Medical Journal* is to be congratulated on its presentation of the article, "The Peanut Worm and Pellagra," by Dr. Henry P. DeForest, of New York City. It is at once the most informative and profusely illustrated article on pellagra that we have read. Whether the conclusions of the author as to the cause of pellagra are correct we, of course, do not know, but the entire article is worth reading and preserving.

IT would seem sound practice to invite our four delegates to the House of Delegates of the A. M. A. to sit in on the sessions of the Indiana House. We are sure they will be of more service to us in the parent body House if they are cognizant of the problems discussed and the various actions taken in our own House of Delegates. It is not necessary that the Constitution and By-Laws be changed so that they can become members of the Indiana House; they may be invited to attend these sessions as guests of the House. We believe there would be no objection to this on the part of any of our delegates.

"IN the field of medical science . . . I am inclined to doubt whether the ideal relationship has yet been everywhere established, between research in the universities and the hospitals on the one hand, and that associated with the pharmaceutical industry on the other. The finding and acceptance of a proper relationship, however, is vital to the progress of both alike, and to their union in an ordered advance along the common front of medical science and its applications."—From the address delivered at the opening ceremony of the Merck and Company Research Laboratory, April 25, 1933, by Sir Henry H. Dale, of London.

AN interesting note is found in the current number of the *Birth Control Review*, in an article on compulsory sterilization. It cites the fact that Indiana was the first of the states to enact a law covering any phase of legal sterilization, this law having been passed on March 9, 1907. It was held unconstitutional in 1921. The bill, as we recall, was sponsored by Dr. David C. Peyton, then the head of Jeffersonville prison. There was no compulsory clause in the law, the entire matter being left to the prisoner and the prison authorities. The records show that 385 inmates were sterilized during the fourteen years that the law was in effect.

For your benefit, the Indiana University School of Medicine is conducting a two-weeks' postgraduate course in Indianapolis, beginning Monday, June twenty-sixth. There will be a prescribed first week, which will include:

Lectures, clinics, and demonstrations;
Meeting of county society secretarics;
Talks by prominent out-of-state alumni;
Class reunion dinners;
Symposia on gastrointestinal discases, diseases of the thyroid, arteriosclerosis, and many other subjects;
Talks on life insurance, medical economics, and investment of savings, all by competent authorities.

The second week will be an "individual" week, and the subjects presented will depend upon subjects requested. Make known your wants. This will be a clinical week; there will be no didactic work.

Registration fee of $2.50 will entitle a physician to attend any onc lecture or the whole course of two weeks. He may stay for as many or as few sessions as he likes.

A leading hotel has made special rates of $1.50 per day for room with bath.

For complete details, write to the Registrar, Indiana University School of Medicine, Indianapolis, Indiana. **See the program printed on page 304 and adv. p. xv in this issue.**

Most of the county societies of the state have had their annual meeting on medical economics, to which have been invited the president and members of the executive committee of the Indiana State Medical Association. Without exception we believe that these meetings have been very much worth while, both in getting the members of the executive committee in intimate touch with the local problems as they affect the individual physician in the various parts of the state, and getting the individual society acquainted with the many national trends in political, economic and social life that are affecting the medical profession. If you have not yet had your meeting upon medical economics, we would suggest that you get in touch with the headquarters office, 1021 Hume Mansur Building, Indianapolis, and make arrangements for it.

THE officers of your Association, together with the numerous committees, are working as never before in an attempt to solve some of the perplexing and vexing problems that are now confronting our profession. On a recent Sunday afternoon in Indianapolis, we had the pleasure of "sitting in" on a general committee conference, and we were astounded at the interest manifested and at the reports of work already done and in the doing. When one considers that practically all of this work is done at the expense of the individual rather than of the Association, one ceases to wonder why the Indiana State Medical Association has reached such a high standing. It has become no small task to accept either an office or a committee chairmanship in our Association; it means work and plenty of it, and we are pleased to be able to say that we seem not to have even one committee chairman who is not giving the best possible service.

A RATHER interesting clipping from "Voice of the People," in the Chicago *Tribune* is as follows: "Pittsburg, Pa., April 22.—Wouldn't it be a hell of a mess if the physicians or psychiatrists called in during a trial to pass upon the sanity of the defendant didn't know whether their fee was to come from the prosecution or the defense?" Come to think of it, the writer of this squib has plenty on which to base his question. For many, many years we have made similar observations; in fact, in most any of the famous murder trials we find physicians lined up for and against the defendant. It is no wonder that the average juryman completely ignores this type of "expert" testimony in arriving at his conclusion as to the guilt or innocence of the defendant. We long have advocated the medical commission plan of handling these and similar situations. The controversies so commonly noted in hearings before the State Industrial Board would become *passé* did we but institute the commission plan.

THE annual meeting of the American Medical Association will be held in Milwaukee the week of June twelfth. The usual railroad rates of one and one-third fare for the round trip will prevail, under the certificate plan. On purchasing your going ticket ask for a certificate; have this properly endorsed while at the meeting and your return ticket will cost you one-third the regular fare. Milwaukee has ample hotel facilities for all and we are promised reasonable rates for these accommodations. Private information, by the grapevine route, is to the effect that Mr. Schlitz, Mr. Pabst, and several other representatives of old Milwaukee families are making special arrangements for your entertainment; it is even intimated that one or two of them may open their gardens for the occasion. Indiana should be well represented at this meeting, since Milwaukee is so convenient. It should also be borne in mind that the Century of Progress, in Chicago, will be in full swing, and a visit to this wonderful exposition may well be coupled with the Milwaukee trip.

THE Better Business Bureau of Indianapolis has formed a Solicitation Committee, an impartial committee of prominent business men and public officials who will provide, through the Bureau, a clearing house of authentic information on all charity solicitations in Indianapolis. This will be of interest to physicians who perhaps more than any other class of individuals are subjected to solicitation by charity organizations of one kind or another. The Bureau's *Bulletin* calls attention to the fact that it is reasonably estimated that not less than one hundred thousand dollars is annually contributed in Indianapolis by business and professional men and the public for alleged charitable purposes, none of which actually finds its way into the support of legitimate charity. The giver is misled as to the facts about the organization or the individual calling upon him, and money is contributed to professional promoters instead of to those who are really in need of charity. The committee will endeavor to obtain complete information about every solicitation in the city and individuals may inquire before they donate. We believe that this is a highly commendable step; we hope that such an effort to eliminate charity grafts will be attempted in every community so that physicians and others may avoid wasting their contributions upon worthless charity benefits, campaigns, "missions," "armies," ticket sales, etc.

AFTER quite some lull we find our advertising physicians again becoming active, judging from complaints sent in and from some personal observations. We have never been able to understand why a news story is enhanced by having the name of the physician appended thereto, very often with what appears to be a direct statement from said physician; that is to say, it is apparent that the story was gotten first-hand, else the reporter could not have been so technical in his story. Newspapermen, even the metropolitan press representatives, know that the rank and file of medical men are sticklers in the matter of publicity, and that it is embarrassing to them to have their names tacked onto a news story. On the other hand, we have far too many who like this sort of thing and many items bearing their names are self-inspired. Some time ago, in conversation with an editor of a paper in one of our larger communities, the editor remarked that a physician had sent in so many stories of his prowess that he, the editor, was forced to call a halt and issued the order that all such stories should be killed, at least for the time being. As a rule it will be found that news items of this character come directly from the physician. It is also noted that those who have seriously

objected to this form of publicity are seldom featured in news stories. A little activity on the part of the local medical societies would seem to be in order.

NOTWITHSTANDING the trend of the times, there seems to be no let-up in the ever-increasing lust of "promoters," all of whom are after the elusive dollar of the large crop of suckers brought forth every year. It seems that people never will learn to investigate ere they part with their money. We wish that all our members might read the monthly bulletins of the Indianapolis Better Business Bureau, and particularly the April number. It teems with exposures of various swindles, for it appears that the spring crop is a bit larger than usual. Among the interesting items are those concerning "Adulterated Paint—having as much as 32.20% of water content; Texas Turkey Farm Syndicate; School of Mechanical Dentistry; Handmade Lace; Heat Distributors; Missing Heir Schemes; Germania Tea; Scenario Racketeers." All of which makes a most interesting list. Nor are these promoters all wet in pushing their schemes at the present time; what with the stock market out of the picture for most of us, with the bond business at a standstill, those with a few hundred dollars on hand are quite put to it to find some place where an investment may be made that will bring fairly large returns. While it is true that Liberty bonds assure a safe investment, yet the return of approximately four per cent is not enough to satisfy many investors; they want larger incomes and hence are more likely to listen to the wiles of the slick and glib sales-artists with their stories of ten and more per cent. A telephone call, or often a three cent stamp, may save considerable money, if judiciously used.

MODERN legislative methods seem to consist in passing a law, and issuing a lot of regulations concerning it. The Indiana Beer Bill is a very good example; there are so many regulations already promulgated, and so many under discussion, as to leave the average Indianian in much doubt as to his "rights" in the matter. We used to complain of too many new laws—now we complain of too many regulations regarding the laws. Some of these are most wise but a few are about as nonsensical as can be. We specifically refer to one of the regulations regarding the change in the law licensing automobile drivers. We might comment on the questions asked of the applicant, since there is much therein that merits comment, but our chiefest interest is in the reverse side of the blank, our attention having been directed to it by Dr. L. W. Brown, of Fort Wayne. This consists in a required statement from a freeholder to the effect that "applicant is a resident of said county and is personally known to me and is mentally and physically fit to operate a motor vehicle upon the highways." All of which may be very impressive to some applicants, but to medical men it is certain to bring at least a smile. How, in Heaven's name, can the average freeholder certify as to the mental and physical qualifications of a casual acquaintance? By what piece of necromancy does he undertake to aver that said applicant has normal vision, a normal heart, a normal blood pressure, normal hearing, full use of his arms and legs—we might go on indefinitely naming the various things that might serve to hamper one in the proper management of such an instrument of danger as the automobile—by what method does he arrive at such a conclusion? We are not prepared to demand that a complete physical examination be made of all applicants, but why make a farce of it? The licensing authorities know, medical men know, and the public knows, that scores, and hundreds are annually licensed who for various reasons should not be permitted to drive a car under any conditions. A locomotive engineer, ere he is seated on the right side of an engine, undergoes a long period of training; after he reaches that post he has a complete physical examination at regular intervals; his motor, be it remembered, does not wander, helter-skelter, over the country; it remains on two rails. We believe in proper legislation but we have no regard for the inane type, as exemplified in this regulation regarding licensing of drivers.

ANENT the socialization of medicine. The populace still takes delight in human sacrifices. Under our veneer of civilization there is a streak of barbarity remaining. We conjure up all kinds of dark accusations against a victim, feeding our imaginations on them until we actually believe them. Then we are not satisfied until vengeance has done its perfect work.

Just now the medical profession is in danger of becoming the scapegoat for our baser passions. There are charges being passed about, and investigations being made, and talk of the so-called socialization of medicine, all of which the man in the street understands only in a hazy way, just sufficiently to induce him to mark the doctor as his next victim.

We believe, therefore, that the time has come for business and professions to speak with a united voice and make secure for all time the position of individual initiative and distinguished service of the medical practitioner. It is a matter which concerns all of us and the brunt of the battle must not be left entirely to the doctors themselves. They are working forcefully in their own cause, as witness the inaugural address of Dr. Terry M. Townsend on taking the office of president of the Medical Society of the County of New York.

"In the last analysis," he said, "the quality of medical service depends on the calibre of the men who give it. Surround practice with bureaucratic regulations and political intrigue, deprive the phy-

sician of an adequate reward for his efforts, deny him the opportunity for continuous study and painstaking work, and what do you have? The most magnificent buildings, the most perfect organization, but you will not produce good doctors under such conditions."

Dr. Townsend pointed out that more has been accomplished in the 300 years of scientific medicine than in the 3,000 years previous, in assuring the health of mankind; and that in just the past 50 years the percentage of the population over 50 has been doubled, as well as the average expectation of life. These services to the cause of human betterment were accomplished under the free tradition of medicine, which it is now proposed to reduce to a subordinate craft.—*American Business Survey*, April, 1933.

Dr. Townsend was an Indiana product, born and reared in New Albany. Until his recent death he had been an associate of Dr. Ferdinand Valentine, of New York City. The quotation above cited from his presidential address is particularly applicable to present-day conditions; we do not recall having seen anything quite so apropos.

THE Tri-State (Indiana, Illinois and Wisconsin) Hospital Association held its annual conference at Chicago last month. It was attended by hospital officials, serious-minded men and women anxiously looking for solutions to their own particular problems. Most of the subjects discussed were not of especial interest to physicians, but one entire afternoon and evening was devoted to the topic of group hospitalization, and here indeed is a vital contact between organized medicine and organized hospitals. Hospital administrators who previously have been schooled in the clergy or the field of business are usually the most enthusiastic about this plan. Medical superintendents are not so enticed by the alluring promises of immediate financial gain. Dr. E. T. Thompson, of Indiana, ably pointed out the dangers of competition among hospitals and the unfairness of any action taken unless it was concerted and practically unanimous. President-elect Padgett and Executive Secretary Tom Hendricks attended this conference, and the opinion prevailed that in Indiana, at least, no program could succeed unless it met with the approval of the Indiana State Medical Association. Because of the widely divergent views held by doctors and laymen (including nurses, clergymen, and Ph. D.s) on this subject, an unprejudiced observer would conclude that neither side was one hundred per cent correct. Rightly our Association should take a most determined attitude towards any inimical force, but we may find some of our assertions untenable as the times change. It is not inconceivable that a compromise may be effected which will be acceptable and practicable. One danger, possibly as yet unforeseen, will arise when any promiscuous solicitation of hospital patients takes place. Here and there are people who are lukewarm toward the regular doctor. At the time of joining the Hospital Benefit Membership, one may state that Dr. Blank is his physician. Six months later, and for some trivial ailment, he may have called Osteopath Blank or Chiropractor Blank. Perhaps he has to quit work. All at once he remembers that he is entitled to two weeks' hospitalization free of charge. Why not save that much food, linen, etc.? Here is where the cultist, or the unqualified doctor who does not belong to his medical society, marches up to the hospital door and walks in at the request of his patient. Can he be put out? Voluntary hospitals have the legal right to exclude any one not a member of organized medicine if they adopt such a rule in proper form. In all other hospitals, the united stand of the county medical society would be just as effective as the most rigid statute. Group hospitalization in times of financial depression would be sunk by the overload of the malingering patient. Witness the insolvency of compensation insurance carriers because of the widespread inclusion of hitherto non-compensable diseases and abnormalities. The "get-something-for-nothing" habit is threatening to engulf both hospitals and doctors. Unless we wish to be entirely subsidized by the state, let us resist all attempts to interfere with the private and individual relationship that should exist between patient and physician.

THE non-operative treatment of carbuncles is commended in an article by Drs. W. A. White and E. A. Cooney (Int. Surg. Digest, Dec., 1932, page 345). The report is based on a series of 500 cases. Essentially the treatment consists in letting the lesion run its course, with the aid of non-specific foreign protein therapy. The authors used commercial ampules of non-specific foreign protein exclusively. Several kinds were used but "aolan" was preferred. Intramuscular injections into the deltoid or gluteal regions were given. In addition to the gratifying progress of the local lesions there is with this treatment a pronounced euphoria, decrease of pain and sleeplessness, and diminution of toxic symptoms. The rapid local response to the treatment is impressive. All stages in the cycle are affected. There is early demarcation of the lesion and abrupt limitation of extension. Intense reddening and tumefaction are followed in a few days by softening central necrosis, and sinus formation. The liquefied slough is discharged through surprisingly small, cribriform openings, or the openings coalesce, allowing the core to be lifted out en masse. Incision is unnecessary. Even granulation and epithelialization appear to be speeded up, owing to general cell excitation. Intermittent moist heat applications are used as long as inflammation is present. The treatment is ambulatory. Constitutional symptoms are quickly removed. Dosage of protein is regulated according to the response. The authors have not seen protein shock.

THE PRESIDENT'S PAGE

May marks the closing of many county society activities for the summer months. The "Flying Squadron" has climaxed a busy year during this month of district meetings. There was still some conflict in meeting dates, and the Council, through Secretary Hendricks, again asks for more co-operation between districts in order that dates may be selected that will enable the State Association officers to attend each district meeting.

The "Flying Squadron" has also attended, either in pairs or as a body, many county unit meetings, and is greatly encouraged at the universal support given in solving our economic problems.

Group Hospitalization

At a recent meeting, in Chicago, of hospital executives in this section of the country, part of a day and one evening were given to discussion of group hospitalization. Apparently, the hospitals, while anxious to adopt some plans that will increase their income, are hesitating to embrace to any extensive degree the suggestions proposed by Rufus Rorem of the Rosenwald Fund. A great deal of wind seems to have disappeared from his sails, and he still has little to talk about except theory.

If we but continue our quiet opposition to such things as the impracticable suggestions advocated by the majority report and can continue to keep up our courage in the fight for the right in the face of these distressing and discouraging days of depression, there is no question but that right will prevail, and the socialization of the practice of medicine will not occur in our country. The most potent factor in accomplishing our ends is the medical society. The maintenance of the county unit in full force is most important. It is essential and necessary. If we break down there, the practice of medicine will become disorganized and disjointed, and destructive competition will prevail.

Dues

It is imperative that membership be kept to its full quota, and some plans can be adopted in each county whereby doctors who may be temporarily financially embarrassed may be assisted in paying their dues, perhaps on the installment plan.

These men are especially in need of continuance of protection from malpractice suits, since their inability to pay the small society dues foreconcludes their inability to buy such protection from commercial companies, at much higher figures. It is our duty to assist these men to protect themselves. Not only this, but inadequately defended malpractice suits result in verdicts against the defendant, thereby encouraging other suits, and causing a great deal of trouble and worry to all of us. This one benefit alone should encourage one hundred per cent membership of eligible doctors in your county.

Meeting of Committee Chairmen

On May fourteenth all of the chairmen of standing and special committees met with the state officers, councilors and delegates to the American Medical Association. The work accomplished up to date was freely discussed, and plans for the rest of the year taken up.

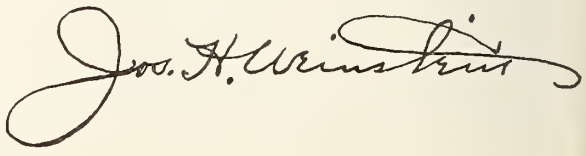
Also the secretary of the State Board of Health met with committees from the University and the State Medical Association to complete details of handling the child welfare work. The questions of tuberculosis, cancer, venereal diseases, and other preventive public health work also were freely discussed, and all of us feel greatly encouraged over the future of the State Board of Health.

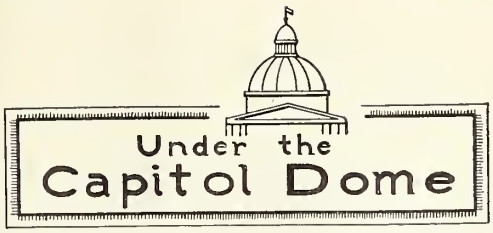
The University is giving freely of its talents and ability, and places its educational resources at the disposal of every county society. For any public health educational program the county society wishes to sanction or sponsor, the University will furnish speakers and demonstrators. Neither the State Board of Health nor the University will participate in nor inaugurate any such work without the request of and participation by the local county unit.

This, in the popular vernacular, puts us "on the spot." Both the majority and minority reports concur in the idea that "the study, evaluation, and co-ordination of medical service be considered important functions for every state and local community, that agencies be formed to exercise these functions, and that the co-ordination of rural with urban services receive special attention."

Should we not rise to this duty and opportunity, never again should we have the temerity to raise our voices against the encroachment of the State Board of Health into our neighborhood without our sanction or consent.

Dr. Olin West, secretary of the American Medical Association, when informed of our State Board of Health plan, wrote: "The success of the new movement will depend on the extent to which the practicing physicians of Indiana will engage in every day practice of preventive medicine. If the practicing physicians do not see to it that the work is properly done, it is inevitable that it will be done by the state." Thus, we are challenged. Let us accept it, gird our loins, and throw down the gauntlet, determined to win the fight.





Indiana physicians may prescribe medicinal whisky, wines and other spirituous liquors in conformity with federal regulations and without any additional state regulations or restrictions, according to Paul P. Fry, state excise director. "Federal regulations will be the Indiana regulations," Mr. Fry said. "Any physician who complies with the federal rules will be complying with the Indiana regulations," he said. New federal regulations which became operative on May fifteenth have been received by the state excise director.

Mr. Fry stated that federal regulations regarding the quantity of alcohol which doctors and dentists may have on hands at any one time also would apply in Indiana.

A brief statement of the federal regulations applying to physicians and to druggists alike, and which apply in Indiana, was issued by Mr. Fry as follows:

The physician may prescribe any amount that in his judgment is required by the patient for thirty days or less. The prescription must state the frequency and quantity of dose, as well as the period of time the liquor is intended to last.

In unusual circumstances the physician may prescribe from thirty-one to ninety days' supply, but in such cases he must endorse "Special" on the prescription and notify the supervisor within twenty-four hours. When the druggist fills such a prescription, he, too, must notify the supervisor within twenty-four hours, stating the quantity and kind, period of time prescribed for, name and address of patient, as well as the name and permit number of the physician.

In all cases the druggist must make sure that the quantity he is dispensing, when taken as directed, does not exceed thirty days' need (or ninety days if a "Special") of that particular patient.

Physicians will continue to use the same prescription, Form 1403, although they must not write them in duplicate, since the form marked "Duplicate" may be used in the same manner as the "Original." This means that instead of 100, the doctor may write 200 prescriptions from each book.

The physician is still required to keep the Form 1402 alphabetical record, wherein he must, in addition, indicate the period for which prescribed.

A new book of prescriptions may be obtained by the doctor before his present one is exhausted, by detaching the back cover of his book and sending it to the supervisor—the stub record to be sent in when the full book has been used.

Druggists may now fill prescriptions within seven days from date of issuance. Forms 1410, application for permits to purchase, do not have to be notarized.

The pharmacist will follow the same procedure and keep the same records as in the past, although it will not be necessary to record the strip stamp number in receiving or dispensing. The canceled prescriptions are to be retained by the druggist and not filed with the supervisor.

The druggist will continue to keep the record Form 1421, in duplicate, the original to be filed with the supervisor, and on it must be indicated, below line 21, the number of the prescription, filled for whisky, brandy, gin or rum of more than one quart each, and the number of prescriptions filled for wine of more than one gallon each.

The amount of spirituous liquor (whisky, brandy, gin, rum and alcohol) that may be withdrawn annually on a non-bond permit is 120 gallons, but only 15 gallons may be on hand at any one time. On a bonded permit the annual quota is unlimited with the quantity on hand governed by the storage space and the amount of the bond. Since alcohol is now classed as a spirituous liquor the quantity to be possessed is reduced by the alcohol on hand.

* * *

Three applicants for licenses to practice midwifery will take examinations on June twentieth in the Chateau Room of the Claypool Hotel. The examination will be conducted by members of the State Board of Medical Examination and Registration.

* * *

The State Board of Podiatry Examiners, comprising three members of the State Board of Medical Registration and two podiatrists, will conduct the annual examination for licenses to practice podiatry on June 8. The examinations will be held in the Chateau Room of the Claypool Hotel. Forty-five applicants will take the examination. They represent the following schools: Ohio College of Chiropody, of Cleveland, Ohio; Illinois College of Chiropody, of Chicago; and Chicago College of Chiropody and Pedic Surgery, of Chicago.

* * *

Harold A. Davis, who graduated from the College of Drugless Physicians of Indianapolis, in 1925, has appealed to the Marion County superior court to require the State Board of Medical Registration and examination to issue him a license to practice naturopathy. Records of the medical board show that Davis attended the college, which will be remembered as the "Briggs Diploma Mill," when he was only fourteen years old. He was in his last year in elementary school at the same time, his course at the college apparently being a night course. Date for hearing his petition in the county court has not yet been set.

* * *

A total of 130 applicants for licenses to practice medicine in Indiana will take the annual examination of the State Board of Medical Registration and Examination on June twentieth, twenty-first,

and twenty-second. The examinations will be conducted at the Claypool Hotel. Seven medical schools will be represented among the young men and women who will take the examination. The schools are: Indiana University School of Medicine; Rush Medical College, of Chicago; Northwestern University School of Medicine, of Chicago; University of Louisville, Louisville, Kentucky; University of Ohio College of Medicine, and University of St. Andrews, Dundee, Scotland.

* * *

This column will carry regularly hereafter a list of physicians who are newly licensed to practice medicine in Indiana. Since January first of this year, the following physicians have been licensed:

Name	Address	State
Jameson, Frank S.	Richmond	N. Y.
Campbell, Guy G.	Wheeler	Pa.
Fullerton, Robert L.	Tipton	Ohio
Cox, Wayne T.	Lafayette	Ky.
Thornton, H. C.	Indianapolis	Ga.
Holland, Philip Todd	Bloomington	N. Y.
Gerrish, Donald A.	Clinton	Ky.
Mahaffey, Hugh	Richmond	Ky.
Falconer, Richard C.	French Lick	Ky.
Cox, Leon T.	Fountain City	Ohio
Smith, Lowell C.	Lafayette	Ohio
Ritchey, John A.	Scott City, Kan.	Ark.
Hoover, Dewey A. (col.)	Terre Haute	Tenn.
Taylor, Fred. Wm.	Indianapolis	N. Y.
King, Myron Scott	Oxford	Cal.
Haller, Thomas C.	East Chicago	Cal.
Briggs, Harry A.	Michigan City	Tex.
Laboe, Edward Wm.	Fort Wayne	Mich.
Smith, Robert D.	Crawfordsville	Mich.

The state medical board is preparing to prosecute one of the allegedly most flagrant cases of practicing medicine without a license and performing a criminal abortion that has come to the board's attention for some time. The alleged illegal practitioner is Harry Franklin, a cook at a Virginia avenue (Indianapolis) restaurant, who performed abortions as a "side line." He is under indictment by the Marion County grand jury. Franklin is reported to have been practicing medicine illegally in Indianapolis for more than a year. According to information obtained by the medical board, Franklin has a previous criminal record, but not in connection with his illegal practice. In 1923 he was sentenced to the Indiana State Farm for violating the prohibition laws; he escaped from the state farm; apprehended later, Franklin was sentenced to the Indiana State Prison at Michigan City. In 1929 he was sentenced to the Ohio State Prison for forgery, under the alias of Harry Frankle. During his term in the Ohio State Prison he was an orderly in the prison hospital and is supposed to have obtained a slight knowledge of medicine there. Prescriptions allegedly written by Franklin were found on file in Indianapolis drug stores.

SECRETARIES' COLUMN

On June twenty-sixth, the secretaries of all the county medical societies will have a meeting at the Indiana University School of Medicine, in Indianapolis. This meeting will begin at 4:30 p. m., and will end with a dinner. It will be held in the afternoon of the first day of the postgraduate course given by Indiana University.

It is IMPORTANT that you be present for this meeting. The information to be gained is for all the members of your society. You will learn that the practice of medicine is being returned to the physicians; that hereafter the practice of medicine as done by the State Board of Health will be done by the county medical society. Full details will be sent to you in a letter within a short time.

Have you answered and returned the questionnaire you received from Dr. A. W. Cavins, 647 Cherry Street, Terre Haute?

How many in your society have not paid their dues? The membership of the Indiana State Medical Association is less now than it was last year at this time. Malpractice suits are ever increasing. Pay your dues and get your protection against any suits that may be filed.

Every county society secretary should read and digest the article in the May issue of THE JOURNAL about the reorganization of the State Board of Health. You will be called upon several times during the year to co-operate with the new board. With the present set-up we can forget the majority report of the Committee on the Costs of Medical Care. We are in no danger in this state, but we do feel sorry for one of our neighboring states. With a little real effort on the part of our secretaries, we can keep state medicine and contract medicine in the background.

The American Medical Association will meet in Milwaukee, June twelfth to sixteenth.

When an outside speaker is to appear on a program for your society he wants to know when and where the meeting will be held; the time allotted for his address; what arrangements are to be made for his transportation to and from the meeting; and whether or not the society will pay his traveling expenses, or the amount of the honorarium. Speakers appreciate, and are entitled to, a courteous note of thanks after they have appeared on a program.

A. M. MITCHELL, M. D.,
Secretaries' Chairman.

Get Set for the
FRENCH LICK SESSION
of the
INDIANA STATE MEDICAL ASSOCIATION
Monday, Tuesday and Wednesday
September 25, 26 and 27, 1933

A special invitation has been extended to members of the Indiana State Medical Association by Thomas D. Taggart, president of the French Lick Springs Hotel Company. Read his letter:

French Lick, Ind., June 1, 1933.

To the Members of the Indiana
State Medical Association:

I am deeply gratified at the opportunity of welcoming the Indiana State Medical men to the convention at French Lick, September twenty-fifth to twenty-seventh, inclusive.



No doubt for many of you this will be the first opportunity to view this property and we have justifiable pride in feeling that you will be proud of French Lick as one of the great institutions of a great state and one whose interests are closely linked with those of all ethical physicians. For many years we have been co-operating with such physicians in caring for patients sent to us for recuperation or for the therapeutic benefits derived from our waters and baths. We hope that in this, the first opportunity for us to get better acquainted, there may be mutual profit and a better understanding of the real benefits derived not only from the use of the natural waters at French Lick, but from the fortified product, which is shipped all over the United States. We hope that a part of the convention will be devoted to an inspection of our modern, up-to-date bottling plant and to the springs themselves from which our famous waters flow.

Looking forward to meeting you personally in September, I am,

Yours sincerely,
French Lick Springs Hotel Company,
T. D. Taggart, President.

FRATERNITY DINNERS

Dr. George Dillinger, of French Lick, is chairman of the Committee on Arrangements and is in charge of arrangements for fraternity dinners, class get-togethers, class banquets, etc., which will be a big feature of this year's convention. A special evening, Tuesday, September 26, has been set aside for these "parties." Make your arrangements with Doctor Dillinger NOW.

HOTEL RESERVATIONS

Make your hotel reservations early. Address your request for reservation to Mr. H. J. Fawcett, Manager, French Lick Springs Hotel, French Lick, Indiana. Rates will be $5 to $9 per day, American plan.

Make Your Plans Now to Attend the French Lick Session

DIPHTHERIA REPORT FOR APRIL, 1933

Six deaths during the month of April compares favorably with nine for the same month last year, eleven for the year 1931, and seven for the year 1930. The total for the first four months of this year is forty-seven deaths, as compared with sixty-two deaths at the same time last year, fifty in 1931, and forty-nine for 1930. We are pleased to report that the number of cases reported is somewhat less than it was last year, in spite of the fact that we have reason to believe that cases are being better reported than they were two or three years ago. We are very much in hopes that we are on the descending limb of a major crest in the lines representing diphtheria mortality. In such case we may expect to go to new low levels.

Now is the time to strike. There is no time so good to attack the enemy as when he is beginning to retreat. The next few months present marvelous opportunities for the prevention of diphtheria next fall when school begins.

Union and Warrick counties entered the black list for the first time. Allen County has very much the highest rate in the state and continues to report deaths and many cases. We cannot understand why Allen County cannot control diphtheria. An epidemic has been raging there for over two years. It has already had five deaths this year; last year it had ten; and in 1931 it had seven deaths. The number of cases that it has reported in those two years runs into the hundreds.

The new organization of the Indiana State Board of Health apparently has the strong support of the entire State Medical Association and it is hoped that the local communities will jump into this thing and see that as many children as possible are immunized. Now is the time to show what organized medicine can do.

The summary for the first four months of this year and the figures for the month of April are shown below:

County	Total for 1933	April, 1933
Allen	5	1
Bartholomew	1	0
Blackford	1	0
Daviess	2	0
Delaware	1	0
Dubois	1	0
Fulton	1	0
Hancock	1	0
Harrison	1	0
Howard	1	0
Jackson	2	1
Knox	1	0
Lake	1	0
Lawrence	2	1
Marion	7	0
Monroe	1	0
Parke	1	0
Pike	1	0
Ripley	1	0
Shelby	2	0
Sullivan	3	1
Switzerland	1	0
Tippecanoe	3	0
Union	1	1
Vigo	1	0
Warrick	1	1
Wayne	1	0
Wells	1	0
Vanderburgh	1	0
	47	6

"VOICE OF THE DOCTOR"

ANALGESIA IN LABOR

Editor THE JOURNAL:

Your editorial in the May issue of THE JOURNAL on "Analgesia in Labor" is the best that I have read. This is in line with my practice and my earnest convictions for fifteen or more years; in fact, I have been using analgesia in labor for twenty years. Reason from cause to effect has been a very serious defect in physicians since Hippocrates. If it had been otherwise, medicine would be as perfect and as well-established a science as is mathematics. Unfortunately, the pioneer in medicine, as in anything else, is isolated; he is looked upon as a crank by his professional brothers, and through them the laity is kept in ignorance. Obstetrics as practiced by the majority of physicians is at least forty years behind the times. Obstetrics is surgery, and if surgery were practiced today as is obstetrics, the surgical ward would be a veritable slaughter pen. If the patient ran the gauntlet of sepsis, he would be terribly handicapped from shock, because of the lack of anesthesia. There is just as much shock from labor in the average primipara who has no analgesia or anesthesia as there is in an appendectomy or herniotomy without local or general anesthesia. I feel satisfied that no one will agree with me except the woman who has experienced it. If a surgeon were to do a major operation without any anesthetic, he would be mobbed, in spirit at least, and he would be denied the use of any well equipped hospital; yet he has entrée into the most refined and best equipped homes in his community and will stand by and refuse to give consideration to the appealing looks and earnest pleadings of the woman in the throes of childbirth; and when it is all over, the woman herself and the onlookers will acclaim him as a wonderful physician.

The members of the laity seem to think that pain in childbirth is a part of the program; by the

same reasoning, pain in cases of gall stone, kidney stone colic, pleurisy, appendicitis, fracture, etc., may be considered a part of the program. Will any physician permit a patient to writhe in agony with gall stone colic and refuse to administer an opiate? If he did so, the physician would be discharged and another physician called. If obstetric patients would demand relief from pain, as do patients suffering with gall stone colic, for instance, there would be a scramble on the part of physicians to learn anesthesia and analgesia in obstetrics.

In every case history that I take, if the patient has been pregnant, I ask whether or not she has had an anesthetic used during labor. About nine-tenths of the answer are in the negative. An affirmative answer usually is qualified by the statement, "Just a little was used." Would any sensible patient return for a gall bladder operation to a surgeon who had done an appendectomy by making the incision, removing the appendix, without anesthesia, and then giving a few whiffs of ether while sewing up the incision? The idea is the same in obstetrical cases.

A woman who gives birth to a baby without analgesia or anesthesia, and who nurses that baby for nine months, does not recover from the shock of that labor during the nursing period. That statement may create a storm of protest, but before any one can qualify as a critic he must compare a woman in labor with modern attention, and one in labor who is compelled to "suffer it out." That latter woman's experience is a disgrace to the medical profession. I consider it my Christian, human, and professional duty to conduct labor cases in such a manner that the patient will have little to tell about later.

B. M. TAYLOR, M. D.,
Portland, Indiana.

WHO ARE THE INDIGENT?

In nearly every discussion concerning public medical service somebody states as though this point at least were not open to discussion, "Of course, the indigent will be cared for free." Why, "Of course?" We have held a different opinion. "Of course" in Indiana the township trustees are required by law to furnish adequate medical aid for their poor and in some counties do pay their hospital bills in full; but why should not each of the indigent pay something?

Our attention was redirected to this question particularly during a recent trip to the Orient. There the poor are indeed poor. The daily wage of common laborers in India is about fifteen cents of our money a day, yet he pays just as much for the necessities of life as do we. We were at first surprised to find that the leading medical missionaries in charge of hospitals, supported in large degree by American churches from donations and therefore intended to be strictly philanthropic institutions, have come to the opinion that absolutely free treatment is actually an injury to these patients. Now, they require of each something; usually an insignificant coin (e. g., two cents a day in the open wards); a bowl of grain; while of those patients who have not even a "mite," some require a few hours of physical work on some public health project in their villages. Others, leaders in this work, think that each should pay an amount equivalent to his daily wage, for each day in the hospital. The amounts thus received from the poor sum up to a small item in the hospitals' budgets. That is not the point. They require such fees from the poor for the poor's sake.

In India the more you do for a man the more he demands, and the less reasonable he becomes. In their bitterly hard life they have learned that in this world one gets little for nothing. The Chinese are an even more discriminating people. They believe that that which they get for nothing is worth just that. Often a man in rags will plead long and earnestly for a reduction in hospital fees, but if even a small one is finally allowed, he refuses to enter. Such hospital care he believes is not good enough for him. Many a mission hospital has greatly increased its patronage as well as its income by merely raising its fees to the level of those charged in non-mission institutions. For Christian missionaries to stress the evil of free medical treatment for the poor is worthy of our attention. If they are right, how about the poor in America?

Medical attention is not an impersonal gift like a ton of coal, a suit of clothes, or an order of groceries, physical commodities which have their own inherent values regardless of the source of the gift, manner in which it is given, and the price paid. Medical service is an intensely personal service; it involves a mutual obligation; a tacit contract in which both patient and doctor have their parts. In addition to the physical drugs given or the operations performed, each treatment implies a mutual confidence. The doctor is to do his best; the patient is to obey orders. But such orders often require a reform in the patient's life in those particulars which enter into the production of his disease. Such changes he will not make unless he has implicit confidence in the doctor.

But why did America and Europe ever adopt the present system of free treatment for the poor? That policy dates back to the time when feudal Europe socially was horizontally stratified and those of the lower classes were indigent because of the accident of their birth. The ruling classes saw to it that they were kept indigent. When, however, these poor fell sick they received remarkable care. "Only such food as is rare and costly; nothing common and cheap," and it was ordered to be "served only in gold and silver vessels." In the hospital courts were fountains of running water (in a desert country) for the convalescent. Story tellers were on duty and musicians played softly all night to quiet those unable to sleep. Also, each patient left the hospital with a new suit of clothes. Nevertheless, when well, these patients continued

to pay for their gorgeous care by oppressive taxes.

Today in this land of opportunity we may well ask of an able-bodied man (we cannot, of course, of children, widows, or invalids) why he is indigent. Sometimes it is because he is lazy, or depraved, or feeble-minded—but more of this later. The thrifty man who has developed a small business is today refused free care in a hospital, and yet he cannot pay for his services there without bankrupting himself. His good-for-nothing brother, on the other hand, is given all of its expensive services free, just because he is "indigent"; that is, because he is "good-for-nothing."

We well remember the experience of the administrators of the (at that time) best endowed general hospital and dispensary in America. They started out to give free medical attention and free medicine to all who were indigent. They soon stopped. The indigent wouldn't take the free medicines. Many of them, after their examinations, were seen to go across the street from the dispensary door to a voodoo shop and buy a charm to cure their ills. The medicines they had received they threw away. After they had learned their lesson this hospital staff started to charge ten cents for each bottle of medicine (a few individual exceptions were made) and the indigent actually took it.

But who today is not in some degree "indigent"? How many of those in full pay wards of a modern hospital are not actually receiving "charity"? In other words, how many of them actually pay in full for what they get? The full pay patient pays his share of the hospitals' maintenance—little more. His fees do not take into account the interest on the investment which the hospital plant and its equipment represent, as does the bill of the guest in a hotel (and a hospital is all that a hotel is, and more, too). Were he in addition to be charged for the attention of the pupil nurses and internes, who now are paid in terms of experience, his bill would be considerably larger. Did his bills for medical service have to cover the expense of those researches which make possible the care he received, as is true of all industries, then it would be very large indeed. In no small degree is every full pay patient of the average modern hospital the recipient of charity. Only very few in de luxe rooms pay in full. The line between the full pay patient and the free patient is not nearly as sharp as some seem to believe.

Also, of this "charity" (unpaid for service) the doctor who sent his patient to the hospital receives far more than does his patient, since he pays no cash at all for the use of the equipment and services which the latter enjoys, and which, were the hospital not there, he would have to provide for himself if he pretends to practice modern medicine.

We do not advocate that the charges for hospital care be raised; rather the reverse; for good medical care is getting more and more expensive and yet should be available to more than now receive it. More and more it is becoming understood that the proper place in which to be sick is in a hospital.

On a few points we all agree. First, that we recognize no grades of quality in medicine. The poor man may pay but a few cents for his meals, and yet the food he gets may actually be better for any man than are the expensive viands of the rich. The poor man may wear coarse, cheap, ill-fitting clothes and yet they actually protect him more adequately than can some of the latest fashions. He may have to rent for his family a hovel in an alley, and yet he may make this a better "home" than is the mansion on the boulevard. But it takes exactly the same length of time and the same skill and the same apparatus to make a correct diagnosis of tuberculosis in a beggar as in a mayor; to operate on the pauper as on the millionaire. The conscientious doctor of the poor, who earned his living practicing among the poor, which he did by making up for the smallness of his fee by their greater number, has been eliminated by modern medicine with its demands of exactness. If he does still exist it is merely because he is a "poor" doctor. The one well enough trained to treat the diseases of the poor cannot afford to treat the poor for what the poor can afford to pay him.

To assist us in our efforts to care for the poor as well as for the rich we have our choice of tax supported medicine, group insurance medicine, or endowed medicine. Which shall it be? Certainly the one which helps us, and therefore our patients, the most. Tax supported medicine, unless secondary to medical education, practically always is poor; group insurance medicine, practically always "contract" medicine, is just as poor.

If we doctors "get busy" we can encourage the creation of endowed institutions which will assist us in our work. Why are we not as active in the education of the public as are those on the social fringe of medical practice (the public health and social service groups) who know less well than we what is best for the public?

CHARLES P. EMERSON, M. D.,
Indianapolis.

If you are licensed to prescribe medicinal liquor you will be interested in the latest interpretation of liquor prescribing regulations, which is given on page 287 in this issue. The state excise director has announced that federal regulations will be Indiana regulations, so that the Indiana physician who complies with federal rules will be complying with Indiana rules. New laws went into effect on May fifteenth. The physician may now prescribe from thirty-one to ninety days' supply, under certain conditions. His prescription book may be used for two hundred prescriptions instead of one hundred. The time limit for having prescriptions filled has been changed from three to seven days. These and other rulings are reviewed in the article above mentioned. A complete outline of the federal regulations was published on page 1549 in *The Journal of the A. M. A.* for May 13, 1933.

DEATH NOTES

THOMAS OLIVER REDDEN, M. D., of Indianapolis, died March twenty-first, aged sixty-six years. Dr. Redden graduated from the Medical College of Indiana, Indianapolis, in 1892.

D. D. MCGILLIVRAY, M. D., of Pine Village, died May fourth, aged fifty-eight years. Dr. McGillivray graduated from the University of Illinois College of Medicine, Chicago, in 1906.

THOMAS CRANDEL, M. D., died in his home in Warren, May sixth. He had not been in active practice for many years. Dr. Crandel graduated from the Eclectic Medical College, Cincinnati, in 1869.

EVERETT R. BEARD, M. D., of Liberty, died April twenty-eighth, aged sixty-two years. Dr. Beard practiced medicine in Liberty for thirty-six years. He graduated from the Medical College of Ohio, Cincinnati, in 1897.

LOSEY LYNN HARDING, M. D., of Frankfort, died in an Indianapolis Hospital, April twenty-eighth, following a long illness. He was forty-five years old. Dr. Harding served as a first lieutenant in the United States Navy during the World War. He was a member of the Clinton County Medical Society, the Indiana State Medical Association and a Fellow of the American Medical Association. Dr. Harding was president of the Clinton County Medical Society for one year, and was its secretary for two years. He graduated from the Indiana University School of Medicine, Indianapolis, in 1917.

HOOSIER NOTES

DR. PAUL D. CRIMM, of Evansville, has been made president of the Evansville Rotary Club.

MISS MARY ALICE KING and Dr. John Dewey Rogers, of Jasonville, were married April eighth.

DR. L. N. ASHWORTH, of Greensburg, has returned to his former location at Connersville.

THE Benton County Medical Society held its regular monthly meeting at Fowler, May sixteenth.

DR. T. M. STALEY has re-opened his office at Bicknell, Indiana, after an absence of several months.

DR. AND MRS. F. G. JACKSON, of Muncie, celebrated their golden wedding anniversary, May sixteenth.

MEMBERS of the Greene County Medical Society met at the County Hospital, Linton, April thirteenth.

A BUSINESS meeting of the Tipton County Medical Society was held at the Commercial Hotel, Tipton, May fourth.

DR. BOYD A. BURKHARDT, of Tipton, has resumed his practice after an enforced absence of six weeks, caused by illness.

A "MEDICAL ECONOMICS" meeting of the Bartholomew County Medical Society was held, May third, at Columbus.

THE Lake County Medical Society held its "Medical Economics" meeting at the Methodist Hospital, in Gary, May eleventh.

MEMBERS of the Kosciusko County Medical Society met at Warsaw, May ninth, for a dinner meeting at the Hotel Hayes.

DR. CHARLES P. EMERSON addressed the members of the Woman's Auxiliary to the Indianapolis Medical Society May twenty-sixth.

THE April twenty-fifth meeting of the Indianapolis Medical Society was held in conjunction with the staff of the Methodist Hospital.

DR. PAUL D. CRIMM, of Evansville, has been elected president of the Trudeau Society, a branch of the Indiana Tuberculosis Association.

DR. J. H. STYGALL, of Indianapolis, talked before the members of the Muncie Academy of Medicine, at the Hotel Roberts, Muncie, May second.

ON June seventh, at Dr. W. C. Moore's farm, near Yorktown, the Delaware-Blackford County doctors will hold their annual outdoor party.

DR. B. G. KEENEY, of Shelbyville, spoke on "Children's Diseases" at the meeting of the Parent-Teacher Club in Shelbyville, April twentieth.

DR. ROY D. MCCLURE, of Detroit, Michigan, was the principal speaker at a banquet of the Nu Sigma Nu medical fraternity, May fifth, in Indianapolis.

DR. A. B. GRAHAM and Dr. J. W. Ricketts, of Indianapolis, were the speakers at the April nineteenth meeting of the Fort Wayne Medical Society.

MEMBERS of the Carroll County Medical Society met at Delphi, April twenty-first. Dr. J. O. Ritchey, of Indianapolis, was the principal speaker.

THE qualifying round for the Indianapolis Medical Society Golf Tournament will be held at the Speedway Golf Course, Wednesday, June seventh.

THE Cass County Medical Society met at Logansport, April twenty-first. Dr. J. J. Moore, of Chicago, presented a talk about clinical laboratory service.

DR. ONA V. WILSON has taken over the Evansville practice of Dr. John H. Hare, recently appointed secretary of the Indiana State Board of Health.

THE Carroll County Medical Society met at Flora, May twelfth, to hear Dr. Charles P. Emerson discuss "Acute Psychosis." Eighteen members attended.

PHYSICIANS of Bedford were addressed by Drs. R. P. Schuler and Paul Ferry, in May, concerning the Kokomo plan of medical relief for the indigent.

MEMBERS of the Jay County Medical Society met at the Country Club, Portland, May fifth. Dr. J. H. P. Gauss, of Indianapolis, discussed diagnostic problems.

DR. MAX BAHR, of Indianapolis, was the principal speaker before the Kiwanis Club, at Shelbyville, April twenty-fifth. His subject was "The Ungeared Mind."

DR. OSBORN A. BRINES, of Detroit, was the speaker before the Fort Wayne Medical Society, May second. His subject was "Autopsy Findings in Sudden Death."

MEMBERS of the Wells County Medical Society met at Bluffton, April eighteenth, to hear Dr. Max Cutler, of Chicago, discuss the recent advances in the treatment of cancer.

DR. J. H. GILPIN, of Fort Wayne, has been appointed by Governor McNutt to the position of superintendent of the Soldiers' Home at Lafayette. Dr. Gilpin succeeds C. F. Zillmer.

DR. KEITH T. MEYER, of Evansville, gave an illustrated talk on "The Science of X-ray in the Practice of Modern Medicine" before the Evansville Kiwanis Club, April thirteenth.

DR. HERBERT S. REICHLE, of Cleveland, lectured on "Some Phases of Childhood Tuberculosis" before the Muncie Academy of Medicine, May ninth. Officers of the Academy will be elected at the June sixth meeting.

DR. CHARLES P. EMERSON addressed the Huntington County Indiana University Alumni Society at its annual banquet, May fourth. He discussed observations made during his recent trip through the Orient.

MEMBERS of the Lawrence County Medical Society met at the Bedford Country Club, May third, to hear Dr. P. S. Perry, of Kokomo, explain the plan carried out in Kokomo for the care of the indigent sick.

THE April twentieth meeting of the LaPorte County Medical Society was held at the Rumley Hotel, LaPorte, with Dr. R. A. Flack, of Lafayette, as the speaker. Dr. Flack's subject was "Early Diagnosis of Goiter."

AT the April session of the Isaac Knapp Dental Society, in Fort Wayne, Dr. Carl G. Miller addressed the members. Dr. Miller explained the functions of the Fort Wayne board of health, of which he is the secretary.

MISS BERNICE BURKHARDT, aged twenty-six, daughter of Dr. and Mrs. A. E. Burkhardt, of Tipton, died in St. Luke's Hospital, Chicago, April twenty-third. Besides the parents, a brother, Dr. Boyd A. Burkhardt, survives.

DR. W. C. MCFADDEN, of Shelbyville, discussed diseases of the heart and arteries, at the meeting of the township farm bureau in that community, May second. Miss Grace Ewing, county public health nurse, made a short talk.

THE annual meeting of the Indiana Dietetic Association was held at the Methodist Hospital Nurses' Home, Indianapolis, April twenty-second. Speakers were Dr. John G. Benson, Miss Colleen Cox, and Dr. Charles P. Emerson.

DR. E. S. JONES, of Hammond, addressed the members of the Jasper-Newton County Medical Society at Rensselaer, March thirty-first. His subject was "New Treatment for Ruptured Appendix." Attendance numbered sixteen.

DR. THURMAN B. RICE presented a paper on "The Education of the Public in Medical Matters" before the Indianapolis Medical Society, May sixteenth. Drs. J. H. Stygall, J. A. MacDonald, and William N. Wishard, Sr., discussed the paper.

AT the May meeting of the Huntington County Medical Society, Dr. C. L. Rudesill, of Indianapolis, presented a very instructive talk and showed x-ray films concerning the subject, "Peptic Ulcer and Related Conditions."

THE Fourth District Medical Society met at French Lick, May seventeenth. New officers were elected for 1934 as follows: R. F. Compton, Osgood, president; Joseph Coomes, Versailles, secretary-treasurer.

THE First District Medical Society, at its meeting, May eighteenth, in Princeton, elected officers for 1934, making Dr. I. C. Barclay, Evansville, president, and re-electing Dr. K. T. Meyer, Evansville, secretary-treasurer.

MEMBERS of the Hamilton County Medical Society met at Cicero, May ninth. Dr. Foster Hudson, of Indianapolis, was the principal speaker, his subject being "Post Partum Care." Attendance numbered twenty-six.

THE Morgan County Medical Society held its regular monthly meeting at the Morgan County Memorial Hospital, May seventeenth. Dr. Sater Nixon, of Indianapolis, presented a paper on "Early Diagnosis of Acute Appendicitis."

THE Hendricks County Medical Society met at Danville, May nineteenth, to hear Dr. James H. Stygall, of Indianapolis, discuss "Tuberculosis." Attendance numbered fourteen. A general discussion followed the presentation of the paper.

THE Association of American Physicians met in Washington, D. C., May ninth to eleventh. Dr. Charles P. Emerson, of Indianapolis, presented a paper before the Association, May tenth. His subject was "Neurasthenia as Seen in the Orient."

THE ninth annual session of the American Heart Association will be held in Milwaukee, June thirteenth. Symposia on acute rheumatic fever and rheumatic heart disease will be presented. The meeting will be held in the Knickerbocker Hotel.

DR. JAMES Y. WELBORN, of Evansville, has been named to serve on the board of trustees of the Boehne Tuberculosis Hospital. Dr. Welborn will succeed Dr. John H. Hare, who has taken over the duties of secretary of the Indiana State Board of Health.

THE Delaware-Blackford County Medical Society held its regular monthly meeting, May sixteenth, at the Hartford Hotel, Hartford City. Dr. L. E. Werry, of Hartford City, presented the principal address, his subject being "Multiple Sclerosis."

THE twenty-fifth anniversary of the organized movement for conservation of vision in America was observed May twenty-fourth by an afternoon entertainment in the offices of the National Society for the Prevention of Blindness, New York City.

DR. FOSTER J. HUDSON, of Indianapolis, presented a paper on "Induction of Labor" before twenty-five members of the Madison County Medical Society at the Hotel Anderson, in Anderson, May fifteenth. This was the regular monthly dinner meeting of the Society.

DR. E. C. ENGLISH, of Rensselaer, was host to fourteen members of the Jasper-Newton County Medical Society, April twenty-eighth. The speaker for the meeting was Dr. Gordon Batman, of Indianapolis, who discussed "Fractures and Their Treatment."

DR. OLIN WEST, secretary of the American Medical Association, talked on "Medical Economics—the Lyman Wilbur Committee Minority Report" before the April twenty-sixth meeting of the St. Joseph County Medical Society. Attendance numbered sixty.

MEMBERS of the Union District Medical Association met at Liberty, Indiana, April twenty-seventh. This organization is composed of physicians in Wayne, Union, Franklin, Fayette, Rush, and Henry counties, in Indiana, and Butler and Preble counties in Ohio.

MEMBERS of the Hendricks County Medical Society met at Crawley Hall, Danville, April twenty-first. Dr. L. A. Ensminger, of Indianapolis, talked about the "Practice of Medicine Before and Since the War." This society now meets every month on the third Thursday of the month.

THE Gibson County Medical Society and the board of trustees of the Methodist Hospital at Princeton entertained with a dinner, April tenth, in honor of Dr. and Mrs. J. G. Benson and Miss Fannie R. Forth, of Indianapolis. Dr. Benson discussed the economic problems of hospitals.

THE American Proctologic Society will meet in Chicago to hold its thirty-fourth annual meeting, June twelfth and thirteenth, with headquarters at the Stevens Hotel. Additional information may be obtained from the secretary, Dr. Frank G. Runyeon, 1361 Perkiomen Avenue, Reading, Pennsylvania.

THE regular meeting of the Sullivan County Medical Society was held at the Mary Sherman Hospital, Sullivan, May third. Case reports were presented by Drs. J. H. Work and M. H. Bedwell; Dr. F. H. Jett, of Terre Haute, talked about the preoperative and postoperative care of the patient.

THE Indianapolis Medical Society held its May second meeting at the Athenaeum. Dr. Maurice Kahler presented a paper on "Experimental Observations on Sex Hormones and Their Relation to Menses," and Dr. Harold Trusler discussed "The Question of Toxemia in Acute Intestinal Obstruction."

THE Wells County Medical Society met at the Bliss Hotel, Bluffton, April eighteenth. The principal address of the evening was presented by Dr. Max Cutler, of Chicago, who spoke on "Recent Advances in the Treatment of Cancer." Physicians from Wells and surrounding counties attended the meeting.

DR. WILLIAM F. MOLT, assisted by Dr. John F. Rigg, of Indianapolis, presented an illustrated talk on the importance of peroral endoscopy in the diagnosis and treatment of disease, at the April seventeenth meeting of the Madison County Medical Society. The meeting was held in the Anderson Hotel.

DR. W. L. BRUETSCH, of Indianapolis, addressed the John A. Andrew Clinical Society at Tuskegee Institute, Alabama, on "The Pathology and Treatment of Neurosyphilis," April tenth. He gave a clinic on "general paralysis" at Vanderbilt University School of Medicine, Nashville, Tennessee, April nineteenth.

THE Bartholomew County Medical Society met at Columbus, May third. This was a "Medical Economics" meeting, with Dr. J. H. Weinstein, president of the Indiana State Medical Association, as one of the speakers. The members of the Jackson County Medical Society were invited to attend the meeting.

THE Chicago Medical Society will have a booth in the Hall of Science Building, Group K, of the Century of Progress Exposition in Chicago. In this booth there will be available information for visiting physicians. The Woman's Auxiliary to the Chicago Medical Society will welcome wives and daughters of physicians.

THE dinner for Indiana University alumni, to be given in Milwaukee during the convention of the American Medical Association, will be held at the New Pfister Hotel, Wednesday evening, June fourteenth, at six-thirty. Dr. J. Edwin Habbe, an I. U. alumni, is one of the members of the Milwaukee Committee for Alumni Dinners.

MEMBERS of the Ripley County Medical Society met at the office of Dr. R. L. Compton, Osgood, May tenth. A rectal clinic was conducted by Dr. Granville S. Hanes, of Louisville, Kentucky. Oil injection treatment of certain rectal conditions was demonstrated. Physicians were present from Jennings, Decatur, and Dearborn counties.

MEMBERS of the Porter County Medical Society met at the Hotel Lempke, Valparaiso, April twenty-fifth. Movies were shown, through the courtesy of Mead Johnson and Company. Township trustees were present at this meeting to discuss methods of caring for the increasing medical poor relief work. Attendance numbered twenty-one.

THE Twelfth District Medical Society held its annual meeting at Potawatomi Inn, at Lake James, May twenty-fifth. An outing for the doctors and their wives was arranged by the

Northeastern Academy of Medicine. Following the dinner in the evening, Dr. Max Ballin, of Harper Hospital, Detroit, discussed "Endocrine Surgery."

THE six hundred volume medical library of the late Dr. L. Park Drayer, of Fort Wayne, has been presented to the Fort Wayne St. Joseph's Hospital. The books will be placed in the staff physician's library, the internes' library and the nurses' library. The addition of Dr. Drayer's books will make a total of 1,500 volumes in the hospital library.

THE Third District Medical Society held its annual meeting at French Lick, May tenth. Speakers were Dr. J. H. Weinstein, president of the State Association; Dr. H. L. Allen, of Bedford; Dr. Frank Walker, of Indianapolis; Dr. John Warvel, of Indianapolis; and Dr. Carl Schoen, of New Albany. Dr. C. E. Boyd, of French Lick, presided over the meeting.

MEMBERS of the Woman's Auxiliary to the Indianapolis Medical Society celebrated National Hospital Day, May twelfth, by dedicating a huge boulder which was placed in the rear of City Hospital, Indianapolis, at the entrance to Memory Lane, in tribute to the doctors of Indianapolis who have given so generously of their time and talents in the City Hospital.

MEMBERS of the Tippecanoe County Medical Society met at the Purdue Memorial Union Building for dinner at 6:15 p. m., May eleventh, with an attendance of fifty. At 8:15 the society congregated at Jefferson High School, with 150 present, to hear Dr. John Sundwall, of Ann Arbor, Michigan. Subjects presented were "Social Trends in Medical Practice" and "The Critical Age of Forty."

THE Indianapolis Medical Society met at St. Vincent's Hospital, May ninth, with the staff of the hospital. A symposium on kidney tumors was presented by Drs. William E. Tinney, James S. Balch, and Karl Ruddell. Dr. T. B. Noble, Jr., presented a paper on "Intestinal Obstruction and Terminal Ileum." Dr. M. J. Barry discussed "Recent Developments in the Treatment of Anemia."

MEMBERS of the Fort Wayne (Allen County) Medical Society, at its meeting May sixteenth, elected officers as follows: Dr. A. L. Mikesell, president; Dr. W. B. Rice, vice-president; Dr. E. L. Cartwright, treasurer; and Dr. L. P. Harshman, secretary. Drs. Cartwright and Harshman were re-elected. Dr. S. P. Hoffman was chosen again as delegate to the state convention at French Lick.

TWO additional patents on the Drinker respirator, covering certain improvements, have been granted to the inventors, Philip Drinker and Louis Agassiz Shaw. One patent covers the use of an adjustable rubber collar designed to fit around the patient's neck, and to seal the neck opening of the cabinet against inrush of air. The second patent covers the use of automatic sealing means for arm ports.

WIVES of members of the Orange County Medical Society met May tenth and completed the organization of an Auxiliary in preparation for the state meeting in September. Mrs. J. H. Weinstein, state chairman of the organization, and Mrs. C. N. Combs, state corresponding secretary, were present. Mrs. George Dillinger was elected president; Mrs. Baker, vice-president, and Mrs. Clarence Boyd, secretary-treasurer.

THE Ninth District Medical Society held its annual meeting at Hazelden, the summer home of George Ade, May twenty-third. Golf kept the visitors busy in the forenoon, and a scientific discussion in the afternoon included Drs. R. F. Woodyatt, Vernon C. David, and Edwin M. Miller, of Chicago, and Dr. J. O. Parramore, of Crown Point. Evening speakers included Dr. Louis D. Moorehead, of Chicago, and officers of the Association.

OFFICERS of the Eleventh Indiana District Medical Society were elected at the May seventeenth meeting, held in Huntington. President is J. E. Yarling, M. D., of Peru; councilor, George D. Miller, M. D., Logansport; secretary-treasurer (re-elected), O. G. Brubaker, M. D., North Manchester. The next meeting of this district society will be held in Wabash, in October, 1933, and the members will be guests of the Wabash County Medical Society.

ATTENDANCE numbered 125 at the meeting of the Fifth District Medical Society, held in Terre Haute, May fifth. Drs. William Allen, V. S. Simpson, J. H. Pritchett and F. H. Strickler presented a symposium on poliomyelitis. Short talks were made by officers of the Indiana State Medical Association, Dr. J. H. Weinstein, Dr. E. E. Padgett, Dr. A. F. Weyerbacher, and Dr. Murray N. Hadley, and by Dr. John H. Hare, secretary of the State Board of Health.

THE Indiana Tuberculosis Association closed its twenty-second annual conference in Indianapolis, April twenty-seventh. Officers were elected as follows: Dr. W. B. Hice, Terre Haute, president; Dr. M. H. Draper, Fort Wayne, first vice-president; Dr. W. H. Stemm, North Vernon, second vice-president; Dr. A. E. Amos, Indianapolis, treasurer; Mrs. George Daviess, South Bend, secretary;

and Murray A. Auerbach, Indianapolis, executive secretary.

THE Fifth International Medical Post-graduate Course of the Tomarkin Foundation, Locarno, will be held at St. Moritz, Switzerland, August thirteenth to twenty-seventh. Special subjects to be considered will be allergic diseases, diseases of the blood, climatology, rheumatism and arthritis, and diseases of metabolism. Complete program and information may be obtained by writing to the secretary of the Tomarkin Foundation, Box 128, Locarno, Switzerland.

THE Fort Wayne Medical Society met at the Chamber of Commerce Building, May sixteenth, for election of officers. At the previous meeting of this society a resolution was adopted to the effect that the society is not in accord with the present system of basketball tournaments as held in Indiana, and recommended that not more than two games should be played by one team within a period of twenty-four hours; and that no two games should be closer together than eight hours.

THE American Medical Golfing Association, headed this year by Dr. John Welsh Croskey, of Philadelphia, will hold its nineteenth annual tournament over the Blue Mound Country Club course, Milwaukee, June twelfth. Any male Fellow of the American Medical Association in good standing is eligible for membership in this association. Communications concerning the tournament or enrollment should be addressed to William J. Burns, executive secretary, 4421 Woodward Avenue, Detroit, Michigan.

MEMBERS of the Wayne Union County Medical Society enjoyed a chicken dinner at Sunny Brook Farm, near Liberty, May eighteenth. Dr. Paul Fouts, of the Eli Lilly Research Department, discussed the treatment of pernicious anemia. His paper presented the practical side of the question and mentioned the various new methods of treatment. A committee was appointed to confer with the local telephonec ompany to secure a listing of physicians separate from the various "cult" doctors in the telephone directory.

THE sixth reunion of the class of 1903, Medical College of Indiana, will be held at the country home of Dr. W. S. Coleman, between Knightstown and Carthage. The date is Sunday, June fourth, and the day will begin with golf from 10:00 to 12:30; lunch at 1:00 p. m.; reunion and program in the afternoon; and a steak dinner at 6:00 p. m. Dr. Charles N. Combs, the class secretary, has already received twenty-five acceptances, and he is anticipating about forty. This class has always had a reunion every fifth year and hopes to have several more before the finish.

A DISCUSSION of child health and welfare work was the feature of a dinner meeting held at the Athletic Club, Indianapolis, May fourteenth. Those who attended were representatives of the Indiana State Board of Health, Dr. John H. Hare and Dr. Thurman B. Rice; representatives of the Indiana University School of Medicine, Dr. W. D. Gatch, Dr. O. N. Torian, and Dr. A. M. Mendenhall; representatives of the Indiana State Medical Association, Dr. J. H. Weinstein, Dr. E. E. Padgett, Dr. F. S. Crockett, Dr. A. F. Weyerbacher, Dr. O. O. Alexander, Dr. E. M. Shanklin, Dr. W. H. Kennedy, Dr. H. H. Wheeler, Dr. A. M. Mitchell, Dr. Ernest Rupel, Dr. J. H. Stygall, Dr. W. P. Garshwiler, and Mr. Thomas A. Hendricks.

A COMMITTEE appointed by Dean W. D. Gatch, of the Indiana University School of Medicine, to co-ordinate the activities of public health organizations in the State of Indiana, includes the following members: Dr. A. L. Harter, Kokomo, president of the Indiana Dental Society; Dr. J. H. Weinstein, president of the Indiana State Medical Association; Mrs. Glen Gifford, Tipton, Red Cross worker; Mrs. W. J. Hockett, Fort Wayne, president of the Indiana Congress of Parents and Teachers; Judge Donald F. Stiver, Goshen; Dr. John H. Hare, Evansville, secretary of the Indiana State Board of Health, and George C. Cole, state superintendent of public instruction. Dean Gatch is chairman of the committee.

THE second annual dinner meeting of chairmen of standing committees of the Indiana State Medical Association was held in Indianapolis, Sunday, May fourteenth, at the Indianapolis Athletic Club. Those present were: Drs. E. E. Padgett, O. O. Alexander, A. M. Mitchell, F. S. Crockett, E. M. Shanklin, J. H. Stygall, W. P. Garshwiler, M. A. Austin, C. C. Bassett, C. J. Clark, W. W. Washburn, Paul S. Johnson, S. P. Hoffmann, H. O. Mertz, Ernest Rupel, M. N. Hadley, George Dillinger, G. D. Miller, W. D. Little, J. R. Phillips, E. L. Bulson, A. F. Weyerbacher, E. M. VanBuskirk, Sam Kennedy, L. A. Ensminger, R. L. Sensenich, H. G. Hamer, D. F. Cameron, F. S. Crockett, J. H. Weinstein, H. H. Wheeler, and Mr. Thomas A. Hendricks.

IN addition to the articles already enumerated, the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

Cutter Laboratory.

Polyanaerobic Antitoxin, Prophylactic (Tetanus-Gas Gangrene Antitoxin).

Polyanaerobic Antitoxin, Therapeutic (Gas Gangrene Antitoxin).

E. Fougera & Co.

Capsules Lipiodol-Lafay, 0.5 Gm.

Tablets Lipiodol-Lafay, 0.04 Gm.
Merck & Co., Inc.
Calcium Gluconate-Merck.
Phenobarbital Sodium-Merck.
G. D. Searle & Co.
Sodium Morrhuate, 5%, with Benzyl Alcohol.

INDIANA UNIVERSITY NEWS NOTES

DR. FRANK C. MANN, graduate of Indiana University School of Medicine in 1913, has been awarded the William Wood Gehard medal by the Pathological Society of Philadelphia, Pennsylvania. Dr. Mann has been chief of the division of experimental surgery and pathology of the Mayo Clinic since 1924. He has devoted many years of study to the liver and is largely responsible for discovering the value of the administration of glucose in liver disease.

BOYD MAHURON, of Pekin, student in the Indiana University School of Medicine at Bloomington, has been elected president of the Theta Kappa Psi professional medical fraternity.

DR. E. L. LIBBERT, formerly of Lawrenceburg and graduate of the Indiana University School of Medicine in 1924, has been admitted to membership in the Academy of Medicine at Cincinnati. Dr. Libbert has been associated with the Good Samaritan Hospital at Cincinnati for the past four years.

TWENTY-TWO physicians from Indiana, Illinois, Ohio, Nebraska, Tennessee, Texas and Toronto, Canada, specializing in ear, nose and throat, attended a two-weeks' course of study at the Indiana University School of Medicine, April seventeenth to twenty-ninth. The course was conducted by Dr. John F. Barnhill and members of the staff of the otolaryngology department of the I. U. Medical School. The course opened informally Sunday night, April sixteenth, with a dinner at the Indianapolis Athletic Club. Dr. Barnhill presided and Dr. Willis D. Gatch, dean of the school, was a guest. Dr. Barnhill recently conducted a similar course for postgraduate physicians in California. The course held at the I. U. Medical School consisted of clinical work in the forenoon and lectures in the afternoon.

ALLEN HANNA, of Bloomington, senior student in the Indiana University School of Medicine, has been awarded the honor key of the Theta Kappa Psi medical fraternity. The honor key is given each year to the most outstanding senior in the fraternity. Hanna will start his interneship in July at the Methodist Hospital, Indianapolis.

DR. GEORGE S. BOND, head of the cardiovascular-renal diseases department of the Indiana University School of Medicine at Indianapolis, spoke recently before the Skeleton Club of the medical school division at Bloomington.

INITIATION services for sixteen medical school students were held at the Hotel Lincoln, Indianapolis, Friday evening, May fifth. The neophytes were Jack Ferry, Akron; Don Mattox, Terre Haute; Joseph Hanner, Bloomingdale; Donald Spahr, Dunkirk; Bernard Seaman, Mishawaka; Robert Myers, Chili; Dan Stivers, Decatur; Jacob Miller, Greensburg; Marion Kirtley, Crawfordsville; Winfield Scott, Shelbyville; John Rinne, Lapel; Joseph Farrell, Indianapolis; M. J. Bohanon, Terre Haute; Stewart Coombs, Terre Haute; Jack Pennell, Kokomo; and Edward McArdle, Fort Wayne. After the initiation services a banquet was held at the Hotel Lincoln. An informal dance was given for the newly initiated members Saturday night at the Indianapolis Country Club.

TWO changes in the executive staff of the Indiana University School of Medicine at Indianapolis have been announced by Dr. W. D. Gatch, dean of the school. J. B. Howe Martin has been appointed administrator to succeed Dr. E. T. Thompson, who has resigned, and Miss Cordelia Hoeflin has been named superintendent of nurses to fill the place made vacant by the resignation of Miss Josephine Hull.



J. B. HOWE MARTIN

Mr. Martin has been purchasing agent and bursar for the medical center of the university for the last year and has been connected with the university since 1913.

Miss Hoeflin formerly was assistant superintendent of the James Whitcomb Riley Hospital for Children, but since 1930 has been supervisor of the Shriner's Hospital for Children at Montreal, Canada.

Dr. Thompson came to the University Hospitals and Medical School as administrator in 1928, after serving five years at the Ancker Hospital at St. Paul, Minnesota.

Miss Hull was appointed head of the I. U. Nurses' Training School last February, after serving a number of years in the University Hospitals.

WOMAN'S AUXILIARY

Our State President, Mrs. Charles F. Voyles, asks the co-operation of all county presidents and secretaries in sending her, each month, news items for publication in the JOURNAL. This is the only way that the Auxiliaries may know about one another.

The Indianapolis Auxiliary has been working in co-operation with the City Hospital and the Indianapolis Park Department on plans for landscaping the grounds surrounding the Indianapolis City Hospital. The area at the west end of the hospital has been planted with many beautiful trees, flowers and shrubbery. In the center of this plot a huge boulder has been placed on which is an inscription paying tribute to the medical profession of Indianapolis. This stone marks the entrance to the avenue of elms which line the memorial walk leading from the hospital ground to the James Whitcomb Riley Hospital for Children.

An elaborate program for the presentation and dedication was carried out May twelfth, National Hospital Day.

Mrs. David Ross was Chairman of the Memorial Planting Committee; other members of the committee were Mrs. William S. Tomlin, Mrs. Henry S. Leonard, Mrs. C. F. Neu, Mrs. J. H. Eberwein, Mrs. J. W. Carmack, Mrs. Chester A. Stayton, Mrs. Nolting, Mrs. T. J. Wheeler, Mrs. Ralph Loring, Mrs. Wm. E. Tinney, Mrs. W. P. Garshwiler, Mrs. O. G. Pfaff, Mrs. Wm. A. Doeppers, Mrs. John R. Brayton, Mrs. D. O. Kearby, assisted by Miss B. E. Gerrin, superintendent of nurses, Dr. Charles W. Myers, superintendent of the hospital, Mr. Earl C. Wolf, nurseries manager, and Mr. Andrew Miller, city park board horticulturist.

THE Woman's Auxiliary of the Vanderburgh County Medical Society elected officers, April eighteenth. Mrs. M. Ravdin is president; Mrs. William C. Caldwell, vice-president; Mrs. J. F. Wynn, secretary; Mrs. A. E. Allenbaugh, treasurer; and Mrs. E. F. Maggenheimer, corresponding secretary.

THE annual meeting of the Delaware-Blackford Woman's Auxiliary was held March twenty-first, at the home of Mrs. R. H. Beeson. A pot-luck dinner was served, after which reports were given, including a resume of the work done by the Auxiliary during the past year. The secon and fourth Tuesday afternoons of each month are devoted to hospital sewing. Election of officers resulted as follows: Mrs. C. M. Mix, re-elected president; Mrs. R. E. Cole, vice-president; Mrs. C. G. Rea, secretary, and Mrs. W. J. Molloy, treasurer.

BOOK REVIEWS

BOOK REVIEWS

OPERATIVE SURGERY. By Warren Stone Bickham, M. D., and Calvin Mason Smyth, Jr., M. D. Volume VII, including General Index to complete work, volumes I-VII. 849 pages, with 765 illustrations. Cloth. Price $10.00. W. B. Saunders Company, Philadelphia and London, 1933.

This is, as its name signifies, a volume of technique on surgical operations. It consists of 616 pages of contents, with a very complete index of 233 pages. The work is remarkably well done. It includes a general summary of surgical principles which is not too long. Comments and explanations are short, clear, and to the point. The outstanding feature of this book is the large number of extremely clear cuts illustrating the various steps in the operation. If there is any criticism of these cuts at all, it is the occasional failure to show the operation completely finished. This is an extremely valuable book for the man beginning work in major surgery who needs to construct in his mind the picture of the procedure before he begins. Plates are especially good in that portion of the book concerning work on the mouth, throat and chest. The chapter on analgesia should be read not only by the surgeon, but by the man in general medicine as well.

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NEW AND NONOFFICIAL REMEDIES, 1933, containing descriptions of articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on Jan. 1, 1933. Cloth. Price, Postpaid, $1.50. Pp. 498; lvi. Chicago: American Medical Association.

The annual editions of this volume contain all that the busy physician needs to know concerning the newer preparations which he is daily importuned by the detail men of the pharmaceutical manufacturers to use. The remedies listed and described here have been examined and found acceptable by the Council on Pharmacy and Chemistry, the deliberative body charged by the American Medical Association with the performance of this service for the practitioner, who has not the time or means to make the determinations for himself. Among the new preparations admitted during the past year are: Trichlorethylene-Calco, an inhalation anesthetic proposed especially for use in trigeminal neuralgia; Nostal, an additional barbituric acid compound; Decholin and Decholin Sodium, bile salt preparations for use in functual insufficiency of the liver, the sodium salt being suitable for intravenous use when necessary; Biliposol, Bismo-Cymol, and Iodobismitol, bismuth compounds for use in obtaining the systemic effects of bismuth, especially in syphilis; Triphal, a gold salt proposed for use in the treatment of lupus erythematosus; a number of improved liver preparations for use in the treatment of pernicious anemia; two halibut liver oil preparations of high vitamin A and vitamin D content; and Pentnucleotide, the sodium salts of the pentose nucleotides derived from the ribonucleic acid of yeast, proposed for use in infectious conditions accompanied by a leukopenia or neutropenia.

The book contains general articles, descriptive of the classification under which the various drugs are listed. According to the preface, more or less thorough-going revisions have been made of the articles: Arsenic Compounds; Dyes, Iodin Compounds; Liver and Stomach Preparations; Radium and Radium Salts and Silver Preparations.

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ANNUAL REPRINT OF THE REPORTS OF THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION FOR 1932. Cloth. Price, $1.00. Pp. 104. Chicago: American Medical Association.

The Council on Pharmacy and Chemistry still carries on its work of informing the medical profession concerning the new medicinal products brought out by the various manufacturers of pharmaceuticals. This volume contains the reports on products considered and rejected by the Council during the past year. Among the reports of special interest are: Amertan,

an unorginial mixture of tannic acid and merthiolate in a water soluble jelly, marketed under a proprietary, uninforming name; Antiopin, a mixture of indefinite composition offered under a nondescriptive, therapeutically suggestive name and marketed in a way that may foster the drug habit; Eubetin, another insulin substitute for oral administration marketed under a proprietary uninforming name with unwarranted claims; Ferro-Copral, a mixture of saccharinated ferric oxide, manganese citrate and copper proteinate proposed for use in the treatment of pernicious anemia and marketed under a proprietary name with unwarranted therapeutic claims; Hepatex P.A.F., a liver preparation proposed for intravenous use and marketed under a proprietary and insufficiently descriptive name with no satisfactory evidence of the safety of its recommended intravenous use; Bi-So-Dol, an unscientific "alkalinizing" mixture offered under an uninforming proprietary name with exaggerated and unwarranted claims of therapeutic usefulness; Gan-Aiden, consisting mainly of the well known ethyl amino-benzoate (benzocaine), a preparation of undeclared composition marketed under a noninforming, proprietary name; Myodin, Subidin, and Sanguiodin, unscientific preparations of iodine marketed with unwarranted claims and indefinite, incorrect statements of composition, under proprietary uninforming names and Tonikum-Roche (Now Elixir Arsylen Compositum-Roche), a "shot-gun" proprietary "tonic" marketed with misleading therapeutic claims.

Besides the reports on rejected articles, the volume contains "Preliminary" and "Special" reports of exceptional timeliness and value: The preliminary report on Thorotrast, a colloidal thorium dioxide preparation proposed for use in retrograde pyelography and for roentgen visualization of the liver and spleen by intravenous administration, is an excellent example of this class of reports. The articles on Nirvanol and Triethanolamine are also interesting and effective preliminary reports. Among the "special" reports those on Sulpharsphenamine and Mercurochrome are outstanding. Each report definitely clears up the present status of the drug concerned, the former, on the basis of a questionnaire circulated among leading syphilogolists, and the latter on the basis of independent bacteriological investigation, done by consultants of the Council.

SOCIETIES AND INSTITUTIONS

INDIANA STATE MEDICAL ASSOCIATION
BUREAU OF PUBLICITY

April 4, 1933.

Present: William N. Wishard, M. D., chairman; E. D. Clark, M. D., and T. A. Hendricks, executive secretary.

Minutes of the meeting held March 24 read, corrected and approved.

Release for publication in Saturday afternoon papers, April 15, "Mumps," read and approved.

Radio releases:

Saturday, March 25—"Your Years and Your Age."

Saturday, April 1—"Spring Exercise."

Additional requests received for pamphlet on prevention of contagious diseases.

There being no further business, the meeting was adjourned.

April 13, 1933.

Present: William N. Wishard, M. D., chairman; E. D. Clark, M. D., and T. A. Hendricks, executive secretary.

Minutes of the meeting of April 4 read and approved.

Radio release, Saturday, April 8—"Dental Research in Relation to the Child."

An outline of the new set-up of the State Board of Health was explained to the Bureau. Under the new set-up the child health work that formerly was done by the Department of Child Hygiene of the State Board of Health is left absolutely up to the local county medical society. The secretary was authorized by the Bureau to prepare a list of suggestions as to how local county medical societies had best undertake this work which the Bureau realizes will be a considerable task, but an obligation that has fallen upon the medical profession of every county society.

The following request for speaker was received:

April 25—Porter County Medical Society, Valparaiso, Ind.

Reports on medical meetings:

March 23—Wayne-Union County Medical Society, Richmond, Ind. "Medical Economics."

March 28—Grant County Medical Society, Marion, Ind. "Medical Economics."

The secretary was instructed to prepare releases in regard to child health day celebrations in Indiana.

There being no further business, the meeting was adjourned.

April 20, 1933.

Present: William N. Wishard, M. D., chairman; E. D. Clark, M. D.; J. H. Stygall, M. D., and T. A. Hendricks, executive secretary.

Minutes of the meeting of April 13 read and approved.

Release for publication in Saturday morning papers, April 29, "Healthy Days Are Here Again," read and approved.

Radio releases:

Saturday, April 15—"Spring Tonics."

Saturday, April 22—"Spring Cleaning."

Request for speaker:

April 25—Porter County Medical Society, Valparaiso, Ind. Word received that speaker already obtained.

There being no further business, the meeting was adjourned.

INDIANA STATE BOARD OF HEALTH
DIVISION OF COMMUNICABLE DISEASES

MONTHLY REPORT, APRIL, 1933

Current prevalence of the principal communicable diseases indicated by the reports from the health officers of the state shows a very slight decrease over the previous month, except for measles and scarlet fever. There were 2,824 cases of disease reported for the current month, and 3,030 cases during the previous month. In April of last year there were 3,847 cases reported for the entire state. Every county in the state reported either positive or negative. A slight decrease was noted in the more common respiratory diseases, especially influenza.

INFLUENZA. A favorable decline was noted in the prevalence of this disease. Only 146 cases were reported during April of this year, while for the same month of the previous year there were 548 cases.

WHOOPING COUGH. Considering the season of the year, the total of 146 cases of whooping cough is very low. However, it is the accepted fact that it is almost impossible to get accurate reports on this disease, as in many instances the majority of parents do not call a physician. Over 50 per cent of the total of cases reported occurred in Marion and Saint Joseph counties.

DIPHTHERIA. There were 80 cases of diphtheria reported during the current month; 121 cases during the previous month: and 131 cases the corresponding month last year.

TYPHOID FEVER. The number of cases (9) of typhoid fever is an increase of only two cases over the previous month, and we consider this very favorable. The average number of cases for April during the last five-year period is twelve.

SCARLET FEVER. There were 944 cases of scarlet fever reported for the month of April, which was a slight increase over the total of 708 cases reported during the previous month. However, this disease usually manifests itself during the spring months, and this total may not be considered alarming.

SMALLPOX. Notwithstanding an increase of four cases in the occurrence of this disease for the current month, as compared with the preceding month, we consider the incidence of the disease very favorable.

MENINGOCOCCUS MENINGITIS. The low total of 16 cases of meningitis which was reported for the month of April represents a noticeable decrease. It has been noted that there has been a steady and gradual decline in the incidence of this disease for the past three months. Forty-three cases were reported during April of 1932.

MEASLES. The total cases of measles (817) reported during the current month is almost twice as many as the total of 414 cases reported during April of the previous year. Marion County reported the majority of cases, there being 545 cases for that county.

The name and number of diseases not mentioned above that were reported the current month are as follows: Tuberculosis, 154; chickenpox, 304; pneumonia, 44; mumps, 171; poliomyelitis, 3; and trachoma, 1.

THURMAN B. RICE, M. D., Director.

NORTHERN TRI-STATE MEDICAL ASSOCIAITION

The sixtieth annual meeting of the Northern Tri-State Medical Association met at LaPorte, Indiana, April 11th, at the Civic Auditorium. About three hundred physicians attended, representing Ohio, Indiana and Michigan, the states which have composed this association since its founding in 1873.

The first address was a fracture symposium by Dr. Paul B. Magnuson, professor of surgery in the Northwestern University, and Dr. R. W. McNealy. Dr. Magnuson condemned employment of metal plates in fracture work, advocating early reduction with sufficient traction to overcome muscle tension. By the use of slides, a new method of repair of fractured hips was demonstrated. Dr. McNealy detailed and demonstrated with slides the various conditions and complications found in fractures of the pelvis; he stated that spinal anesthesia should not be used in this type of case.

Dr. Russell M. Wilder, of the Mayo Foundation, chose as his subject, "Diseases of Parathyroid with Special Reference to Parathyroid Overfunction." He first discussed the syndromes of hypoparathyroidism, stressing the changes in the calcium and phosphorus ratio. Under the subject of hyperparathyroidism he discussed bone conditions, especially osteofibrosis-cystica. His paper was illustrated with slides.

Dr. E. Benjamin Gillette, of the genito-urinary department of the Gillette Clinic in Toledo, addressed the physicians on "Some Diagnostic Points Differentiating Abdominal and Genito-Urinary Diseases." His paper also was illustrated with slides.

Dr. George L. Waldbott, of Detroit, Michigan, discussed "The Control of Chronic Intractable Asthma with Pollen." He presented a clear and concise talk on pollen as an etiological factor in asthma, and he presented reports of cases.

Dr. Arthur E. Hertzler, professor of surgery in the University of Kansas, was a most excellent speaker and entertainer. He discussed some of the phases of appendicitis, and used blackboard illustrations.

Dr. Frederick A. Coller, professor of surgery in the University of Michigan, spoke on "The Delayed Treatment of Advanced Cases of Appendicitis."

Dr. Charles A. Elliott, of Northwestern University, Chicago, presented an address on "The Management of Hepatic Diseases," advocating increasing the glycogen reserve in the liver before operations, especially the gall-bladder, by giving glucose by all methods except the rectum.

Dr. Charles Lukens, of Toledo, talked about "Special Sense Organs as a Factor in Headache." He distributed a well-prepared outline on the general classification of headache. He pointed out the various causes and suggested appropriate treatment.

Dr. Charles P. Emerson, of the Indiana University School of Medicine, discussed "Oriental Observation of Neuropsychoses from the Viewpoint of an Internist." He presented a very interesting discussion regarding the various diseases of India, Africa, China, and Japan.

The officers for the 1933 meeting were: Dr. Edward B. Pedlow, president; Lima, Ohio; Dr. G. O. Larson, vice-president, Laporte, Indiana; Dr. Edward P. Gillette, secretary, Toledo, Ohio; and Dr. H. E. Randall, treasurer, Flint, Michigan. Councilors: Dr. Charles Lukens, Toledo; Dr. P. N. Sutherland, Angola, Indiana; and Dr. Joseph H. Andries, Detroit, Michigan.

Officers elected for the 1934 meeting, to be held at Flint, Michigan, are: Dr. G. O. Larson, president, LaPorte, Indiana; Dr. Edward P. Gillette, vice-president, Toledo, Ohio; Dr. G. E. Jones, secretary, Lima, Ohio; and Dr. H. E. Randall, treasurer, Flint, Michigan. Councilors: Dr. Charles Lukens, Toledo, Ohio; Dr. P. N. Sutherland, Angola, Indiana; and Dr. W. M. Donald, Detroit, Michigan.

CLINTON COUNTY MEDICAL SOCIETY

The Clinton County Medical Society met in regular session at the Coulter Hotel, in Frankfort, May 4, 1933, with Dr. John S. Ketoham presiding.

Upon roll call the following members were noted present: Drs. John S. Ketcham, C. A. Robison, A. G. Chittick, C. A. Burroughs, R. A. Hedgecock, William C. Mount, S. B. Sims, J. A. Van Kirk, F. A. Beardsley, H. R. Royster, M. F. Boulden, N. B. Combs, and I. E. Carlyle.

Dr. Carl H. McCaskey, of Indianapolis, was the guest of the evening.

Communications were read from the publishers of *Medical Economics* and from The American Hospital Association, together with the replies of the society's secretary, refusing cooperation of information, which action was approved by the society.

A communication including the tentative program of the coming meeting of the Ninth District Society was read.

Dr. Ketcham appointed a committee to draft resolutions of respect and appreciation of the life and fellowship of Dr. Losey L. Harding.

Drs. Compton and Carlyle made a report of their contact with the Boone County Medical Society in regard to a malpractice suit coming up in the near future.

Dr. McCaskey presented a paper on the commoner infections of the ear, nose and throat, as seen by the general practitioner. The paper was especially helpful, as Dr. McCaskey emphasized some of the "do's and don'ts" of his specialty. He also assured the members that the heavy fire from the Committee on the Costs of Medical Care seemed to be losing ground in Indianapolis and possibly throughout the state. Nobody seems ready to pay the uplifters.

No further business appearing, the meeting adjourned.

IVAN E. CARLYLE, M. D., *Secretary.*

ST. JOSEPH COUNTY MEDICAL SOCIETY

The St. Joseph County Medical Society met in the Medical Room of the Public Library, Tuesday, April 18, 1933, with President Graham in the chair and twenty-four members present.

The application of Dr. C. D. Linton for membership in the St. Joseph County Medical Society by transfer from the Tippecanoe County Medical Society was read and voted upon favorably.

The papers of the evening were: "Prenatal Care," by Dr. C. F. Bussard; "Postnatal Care," by Dr. H. W. Helman. These papers were discussed by Drs. Wygant and Bolling.

The program chairman, Dr. Cassady, announced that Dr. Olin West, Secretary and General Manager of the American Medical Association, would speak on "Medical Economics," Lyman Wilbur Committee Minority Report, April 26, 1933.

The St. Joseph County Medical Society met at the St. James Parish House, April 26, 1933, for dinner at 6:30 p. m., with President Graham in the chair and sixty-one members and guests present.

Dr. Olin West, Secretary and General Manager of the American Medical Association, spoke on "Medical Economics," Lyman Wilbur Committee Minority Report.

Dr. West sketched briefly the personnel of the majority of the committee, the small number of physicians on it, the time of its duration, the manner of its investigations and the conclusions at which it arrived as a majority.

As a member of the committee signing and making a minority report, Dr. West pointed out the falsity of many of these investigations and the unscientific manner in which conclusions were drawn. Dr. West went back into early history and pointed out the progress that medicine has made steadily during the ages when left untrammeled by politics; that scientific medicine must be left untrammeled in the future if progress is still to be made; that when the practice of medicine loses

its individual contact and becomes a mass production then would scientific medicine cease. He touched on voluntary medical insurance, usually followed by compulsory medical insurance and illustrated the mediocre work in some instances done by the salaried physicians who had the care of these compulsory medical cases.

In closing, Dr. West stressed the physicians' need to carry on, to purge their own ranks of the unfit, to keep their ideals of ethics high and scientific medicine untrammeled.

The paper was discussed by Drs. Sandock, Lyon, Sensenich, and Traver.

The St. Joseph County Medical Society was called to order by President Graham at 8:30 p. m., Tuesday, May 2, 1933, in the Medical Room of the Public Library, with thirty-three members present.

Dr. John E. Luzadder, Jr., of New Carlisle, was elected unanimously by ballot to membership in the society.

The paper of the evening, "Socialization of Medicine," was given by Dr. I. Sandock, and discussed by Drs. Bosenbury, Bolling, Birmingham, Sullivan, Graham, Sensenich, Fish, Traver, and Fisher.

The St. Joseph County Medical Society met in the Medical Room of the Public Library, Tuesday, May 9, 1933, at 8:45 p. m., with Vice-President Dr. Milo Miller in the chair. There were twenty-three members present.

A letter was read from Dr. Sanderson, of Healthwin Hospital, announcing that May thirty-first had been selected for the meeting of the St. Joseph County Medical Society at Healthwin. Dinner would be served at 6:30 p. m. and followed by a lecture on "The Common Conditions Met in Clinical Neurology," by Dr. Lewis Pollock, Professor of Neurology, Northwestern University Medical School, Chicago.

Dr. John C. Boone presented the following papers: "Retropharyngeal Abscess with Comments" and "Hemorrhage from the Pharyngeal Opening of the Eustachian Tube." The papers were discussed by Drs. Savery and Cassady.

Meeting adjourned at 9:15 p. m.

MARTHA BREWER LYON, M. D.,
Assistant Secretary and Treasurer.

LAKE COUNTY MEDICAL SOCIETY

The regular meeting of the Lake County Medical Society was held at Gary Methodist Hospital, Thursday, May eleventh, President Jones presiding.

The minutes of the April meeting were read and approved.

An application from Dr. Charles E. Doneghy, of East Chicago, was read and referred to the Council. Ballott was had on the application of Dr. Carl H. Bendler, of Gary, and he was duly elected.

A statement regarding some correspondence with the International Film Corporation *in re* a proposal to put on a "show" with an admission charge of $1.50 per. The request was denied.

A letter from a former member, Dr. Frank Denny, was read, and the secretary instructed to have the Association JOURNAL forwarded to his address.

Discussion was had *in re* the activities of some of our advertising quacks, and on motion the chair was asked to appoint a committee to see what might be done in the matter.

The perennial medical poor relief problem again came to life, and after much discussion Ver Plank moved that a committee of five be appointed to confer with the Governor's Relief Commission, if and when said commission might care to discuss the matter with the society. The committee was voted full power to act.

On motion, the June meeting was transferred from June eighth to June tenth, due to the fact that the guest speaker for that meeting, Dr. Richard Sutton, Kansas City, would be unable to get here for the earlier date.

The program of the evening was devoted to "Medical Economics," it having been advertised that any member might be heard on almost any subject other than those of a personal nature. This resulted in a pot pourri program, led off by Shanklin, who discussed some of the phases of malpractice suits. The burden of his complaint was that these suits are on a marked increase and that many of them are prompted by comments of physicians in discussing the work of their fellow practitioners.

Dr. H. J. White discussed the distribution of physicians, together with a study of the various health agencies of the country.

Dr. Teegarden presented the plan adopted in East Chicago in the matter of indigent medical relief. He stated that almost all the physicians of his city had endorsed the plan, it being quite like that of Kokomo, as outlined in THE JOURNAL for May.

President Jones offered some comments on the workings of the Governor's Relief Commission for Lake County, the plan being worked out by the commission, of which Mr. Virgil Sheppard is the executive secretary. Dr. Iddings stated that the commission had already put in effect its plans for the country townships and that North and Calument townships were now under consideration by the commission.

After quite some discussion by many members, Ver Plank moved that a committee of five be appointed by the chair, this committee to confer with the commission, if and when they were invited so to do. The motion was unanimously adopted. The chair appointed as chairman, Dr. A. J. Lauer, together with J. R. Pugh, J. A. Teegarden, L. K. Ryan, and A. G. Miller; the president and secretary to serve as ex-officio members.

Dr. Parker, president of the Tenth District Society, announced a June meeting at Hazelden Farm, the home of George Ade; the program for same was to be announced later.

The hour of eleven having arrived and many of the members long past their bedtime hour, the remarks of Dr. Pugh, general chairman of the Economics Committee, were deferred until a later meeting.

Adjourned.

E. S. JONES, *President.*
E. M. SHANKLIN, *Secretary.*

FIRST DISTRICT MEDICAL SOCIETY

The First District Medical Society meeting was held Thursday, May eighteenth, at Princeton, Indiana.

Over one hundred physicians with their wives were in attendance.

The golf tournament was won by Dr. R. W. Wood, of Oakland City, Indiana.

Visiting women were entertained by a puppet show in the afternoon, and with bridge in the evening. Hostesses were members of the Woman's Auxiliary of the Gibson County Medical Society.

A banquet was held at 6:30 p. m., at the Country Club. Speakers of the evening were:

Dr. J. H. Weinstein, president of the Indiana State Medical Association;

Dr. John H. Hare, secretary of the Indiana State Board of Health;

Mr. Thomas A. Hendricks, executive secretary of the Indiana State Medical Association.

The following officers were elected for the enusing year:

Dr. I. C. Barclay, Evansville, president;

Dr. C. A. Miller, Princeton, vice-president;

Dr. Keith T. Meyer, Evansville, secretary-treasurer.

ANNOUNCEMENT

An Intensive Post-graduate Course for Doctors of Medicine is Announced by the Indiana University School of Medicine as approved by the Indiana State Medical Association. *The Course Will Last Two Weeks.*

The first week will consist of fifty-four hours beginning Monday, June 26th, 1933, at 8:00 A.M. and closing Saturday, July 1st, 1933, at 12:30 P.M. This first week is an intensive one, including a series of lectures, clinics and demonstrations, stressing diagnosis and newer methods of treatment. An outline of the subjects to be covered is as follows:

SCHEDULE OF COURSE

MONDAY, JUNE 26	TUESDAY, JUNE 27	WEDNESDAY, JUNE 28	THURSDAY, JUNE 29	FRIDAY, JUNE 30	SATURDAY, JULY 1
8—8-8:20 Rectal ether analgesia in obstetrics 8:20-8:40 Breech presentation (moving pictures) 8:40-8:55 Toxemia of pregnancy	8-8:55 Surgical Clinic	8-8:30 T.B. infections of lung 8:30-8:55 Non - tuberculous infectious processes of the lung	8-8:20 Burns and burn defects 8:20-8:40 T.B. of hips and spine 8:40-8:55 Spastic paralysis	8-8:30 Palliative treatment and indications for surgery in prostatism 8:30-8:55 Transurethral prostatectomy	8-8:30 The malaria treatment of general paralysis and tabes 8:30 - 8:55 Differential diagnosis between central, peripheral and functional conditions
9—9-9:15 Obstetric clinic 9:15-9:30 Obstetric clinic 9:30-9:45 Occiput posterior 9:45-9:55 Obstetrics in the home	9-9:30 Intestinal obstruction 9:30-9:55 Intestinal obstruction in advanced appendicitis	9-9:30 Anaemia and Polycythemia 9:30-9:55 Leukemia: diseases of Leukopoetic system	9-9:20 Poliomyelitis 9:20-9:40 Osteomyelitis 9:40-9:55 Fractures of neck of femur	9-9:30 Urinary lithiasis 9:30-9:55 Renal infections in childhood	9-9:30 Nephropathies 9:30-9:55 Angina Pectoris
10—10-10:20 Non-malignant lesions of the cervix 10:20-10:40 Early signs and symptons of uterine cancer 10:40-10:55 Backache in gynecologieal patients	10-10:20 Anaesthesia 10:30-11:15 Appendicitis	10-10:30 Purpura, hemorrhagic dyscrasia 10:30-10:55 Nutritional disturbances	10-10:20 Plastic surgery of the head and neck 10:20-10:40 Reconstructive surgery of the foot 10:40-10:55 Congenital deformities	10-12 Symposium on arteriosclerosis 10-10:30 General vascular changes 10:30-10:45 Eye changes 10:45-11:15 Mental changes	10-10:30 Allergy 10:30-10:55 Therapeutics
11—11-11:20 Pelvic genital tumors. Clinic 11:20-11:40 Dysmenorrhoea 11:40-11:55 Pelvic genital infections. Clinic	11:15-11:55 Clinic—Diseases of the breast	11-11:55 Epidemic encephalitis and encephalitic Parkinsonism	11-11:20 Low back pain 11:20-11:40 Fractures of the forearm 11:40-11:55 Fractures of the upper humerus	11:15-11:45 Sclerotic heart disease 11:45-11:55 Surgical management of peripheral vascular lesions	11-11:30 Diabetes: General consideration 11:30-12:30 Complications of diabetes and management. Diabetic clinic
12-1:25 Luncheon	Luncheon	Luncheon	Luncheon	Luncheon	Luncheon
1:30—1:30-1:50 The new born—his problems 1:50-2:10 The premature and how to handle him 2:10-2:25 Procedures in infants. Transfusion, lumbar puncture, simple fluids	1:30-2 Cardiospasm 2-2:25 X-ray disgnosis and treatment of diseases of the gastro-intestinal tract	1:30-2 The rheumatic heart 2-2:25 Luetic heart disease	1:30-2 The nose: nasal mechanics, nasal obstruction, acute colds 2-2:25 The pharynx. Infections in mouth and throat. Tonsil infection. New growths	1:30-1:45 Clinieal syphilis 1:45-2 Serology 2-2:15 Treatment methods 2:15-2:25 Complications	
2:30—2:30-3 Normal feeding, to cover: breast feeding, simple milk feeding, protein milk 3-3:20 Childhood tuberculosis	2:30-3 Peptic ulcer 3:00-3:25 Colitis and constipation	2:30-3:45 Medical and surgical clinic on the thyroid	2:30-3 The ear. Etiology and treatment of acute and chronic ear infections 3-3:25 The mastoid. Etiology and indications of acute infection. Diagnosis and complications of chronic mastoid infections	2:30-2:45 Eczema 2:45-3 Lymphogranulomatosis inguinale 3-3:15 Mycoticinfections 3:15-3:25 Neoplasms and new growths of the skin	
3:30—3:20-4 Contagious groups and how to handle them, e.g. Prevention as applied to the following: measles, scarlet fever, pertussis, polio, erysipelas, vaccination 4—4:45 Examining the child. Motion picture	3:30-4 Cancer of rectosigmoid 4:00-4:25 Rectal diseases	3:45-4:15 Arthritis 4:15-4:25 Surgieal management of arthritis	3:30-4 Clinic. Diseases of the gall bladder and biliary ducts 4-4:25 Non-surgical diseases of liver and bile passages	3:30-3:50 Treatment of acute gonorrhoea 3:50-4:10 Complication of acute gonorrhoea 4:10-4:25 Late gonorrheal sequellae	
4:30—4:30-7:55 Child health and maternal welfare. This time given over to a meeting and dinner for County Society secretaries	4:30-5 External eye diseases 5-5:25 The fundus in relation to general disease	4:30-5 Subacute bacterial endocarditis 5-5:25 Cardiac irregularities Movie	4:30-5 Present day theories of immunity 5-5:25 Treatment of acute infections	4:30-5 Heat in modern therapeutics 5-5:30 Recent advances in laboratory methods	
5:30-7:55 Dinner for County Secretaries	Dinner	Alumni Home-coming Dinner	Dinner	Class reunion dinners	
8—8-8:30 Obstetrics. Calcium deficiency in pregnancy 8-8:10 8:10-8:30 Obstetrical diagnosis 8:30-8:55 Poisons; some suggestions for aiding patient or coroner	8-8:30 Muscle abnormalities of the eye 8:30-8:55 Differentiation of glaucoma, iritis, cataract	8-8:30 Medical alumni 8:30-8:55 Surgical alumni	8-8:30 Diagnosis of valvular heart disease 8:30-8:55 Savings and investments	8-8:55 Medical talk	
9—9-9:40 The common days work of the pediatrician 9:40-10 Upsets in nutrition; diarrhoea, scurvey, rickets	9-10 Practical problems of urologic diagnosis	9-9:30 Medieal alumni 9:30-10 Surgical Alumni	9-9:30 Laryngeal diseases and new growths 9:30-10 The sinuses: infections, etiologic factors, local and general. General treatment. Prevention and cure	9-9:30 Life insurance 9:30-10 Medical ethics	

SECOND OPTIONAL WEEK—July 3, 1933-July 8, 1933

A second optional week will be available in any of the branches of medicine and surgery and the specialties, including ward walks, wet and dry clinics, clinical pathological conferences, round table conferences, assigned readings, special laboratory technique and topographical anatomy. The optional courses will be given only in those subjects for which sufficient applieations are received prior to June 20th. Those interested in further details regarding part or all of this course may communicate with the Registrar of the Indiana University School of Medicine and further information will be sent. A registration fee of $2.50 will entitle any doctor of medicine in good standing to the entire course.

Special features of the course will consist of a meeting of the County Medical Society Secretaries to discuss child health and maternal welfare in cooperation with the State Board of Health under the new plan.

Symposia will be held on diseases of the gastrointestinal tract, the thyroid, arteriosclerosis, and fractures.

An alumni home coming day will be one of the special attractions. Evening talks will be given by prominent alumni of the Indiana University School of Medicine. Other unusual features will include discussion of savings and investments and life insurance by competent authorities.

The programme will include speakers of national reputation.

A leading hotel has offered accommodations to doctors attending the course at a special rate ($1.50 daily). Noon day meals on the campus will be furnished by the school at a low cost.

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ORIGINAL ARTICLES

FRACTURE OF THE HIP

E. B. MUMFORD, M. D.
INDIANAPOLIS

A study of the problem of the fractured hip leaves one somewhat dazed as the full realization of the seriousness of the lesion unfolds itself. The mortality rate (25%) is sufficient in itself to make this accident a dreaded one, but the deep meaning behind the surgeon's guarded prognosis is the high incidence (30%) of non-union with the associated pain and loss of function which makes almost unbearable the "winter" years of life of these unfortunate victims.

This discussion of fracture of the hip is based upon a study of fifty-one cases including intra-capsular and inter-trochanteric types. Thirty-six (70.6%) were females, fifteen (29.4%) were males. The average age in twenty patients was 68 years, one between 15 and 20, one between 40 and 50, twelve between 60 and 70, four between 80 and 90, and two past 90 years of age. All were treated according to the Whitman plan of reduction but with a modification of the type of splint for fixation. Death occurred in fourteen cases (27.45%). A good result was obtained in twenty-seven (52.9%), fair result in six (11.65%), non-union in four (8%). Thirty-five cases were fixed with full double spica plaster of Paris splints and sixteen were fixed with similar plaster splints but without any back to the splint ("no-back" splint).

Fracture of the hip, including intra-capsular and inter-trochanteric fractures of the femur, is rare in children, uncommon in middle age, and common in late life, 75 per cent occurring in those patients past 60 years of age.

The real causes or conditions which make this a lesion of the aged is not clear but one must offer as an explanation either a weakening of the bony tissue through senile changes or a lessening of the normal muscular protection of the skeleton through a decrease of the muscle reflex activity. Although "osteo-porosis senilis" is frequently mentioned and described in the literature, that a degenerative or senile change has occurred in the bone has never been proven nor do the x-ray studies of the early fracture in the femur indicate any decalcification or rarefaction in that portion of the bone involved. The incident of fractures in other bones of the aged does not support the thought that in old age the bones have become brittle or have become weakened through a decrease in lime salts nor is non-union, other than in hip fractures, more common in patients past 60 years of age.

A study of the physical construction of the body will show that the weight above the pelvis is transmitted to the lower extremities through an angle in the skeleton formed by the neck and the shaft of the femur. Most investigators state that this femoral angle is greater in childhood and becomes less in adult life and also that it approaches nearer a right angle in the female than in the male. Stimson states that there is but little difference in the angle at different ages and that the average femoral angle is from 125 to 130 degrees. Gray gives the average in adult as 125 degrees and less than in early life. Jones and Lovett give the figures of 160 degrees for children and 125 degrees for adults. The greater femoral angle in children may account for the lesser incident of fracture of the neck in this age while the approach of the femoral angle to that of a right angle in females may be a factor in the higher percentage of fractures in this sex.

The importance of muscular activity in the protection of the skeleton from strains and stresses is well recognized. This muscular protection decreases in efficiency in direct proportion to age, the muscle reflex being strong and quick in early life and weak and sluggish in old age, and perhaps one may assume that the female has less muscle protection for the skeleton than does the male.

It would seem rather logical to explain the frequency of fractures of the hip upon physical and physiological bases rather than upon pathological or chronological changes in the bone tissue, upon the basis of the weakness of the femoral angle which weakness increases with age through a lessening of the angle (approaching more a right angle) and upon the basis of a lessening of the normal muscular protection to the skeleton rather

than upon the basis of a decalcification or increase of brittleness of the bone.

History

The history in a case of fracture of the hip is usually that of a sudden unexpected twist of the body or a fall from a standing position or a shifting of the weight. Rarely is any violence a factor in the accident. A slip on a rug, a fall of one step, a sudden turn of the body, an unexpected push of the person are all common stories as the cause of the fracture.

The symptoms are pain and loss of function in the affected leg. The signs are deformity, shortening, and shock. The pain is a variable symptom in that it may be absent or slight or of a most severe type. Many instances are recorded in which the patient does not realize that an injury to the bone has occurred. As a rule, however, the pain is present from the first and is increased through any motion of the leg or even through muscle spasm. The sharp, shrill cry which comes at this time is most characteristic. The loss of function is also a variable symptom in that weight-bearing and locomotion are possible with but little or no discomfort or the patient may be unable to move the leg to any degree. The deformity is that of slight flexion with outward rotation of the leg, the foot at times being everted to a right angle. If there is no displacement of the fragment, this deformity may be absent. Shortening is due to the overriding of the fragments and to the change in the femoral angle as a result of the abduction of the upper and the adduction of the lower fragments. Crepitation is rare and should never be sought.

The diagnosis of an impacted fractured hip is not uncommon. It is the opinion of the writer that a true impaction at the line of fracture is rare and never occurs with a deformity of outward rotation of the leg. In those cases in which there is no deformity it is possible that some impaction may be present.

The error in diagnosis is due to a misinterpretation of the x-ray findings. In the standard anterioposterior shadow (Fig. 2) of the upper end of the normal femur with the leg in a neutral position of rotation the entire length of the neck of the femur is shown and forms an angle (femoral angle) with the shaft of 125 degrees. The lesser trochanter lying behind the shaft is seen only as a small tip while the greater trochanter lies some distance from the upper rim of the acetabulum. In a fracture of the neck of the femur (Fig. 1) in which there is outward rotation of the outer fragment and with the usual abduction of the inner fragment and adduction of the outer fragment the shadow picture is quite different. The femoral angle approaches that of a right angle, the neck is much shorter, the lesser trochanter appears larger and the greater trochanter is close to the pelvic bone. There may also be some evidence of an upward displacement of the outer fragment. The lesser femoral angle is due to the abduction of the inner fragment and the adduction of the outer fragment. The apparent shortening (which is very often interpreted as an impaction) is due to the position of the fragments, the inner fragment lying to a great part behind the outer portion of the neck which is pointing forward. The changes in the shadows of the greater and lesser trochanters are due entirely to outward rotation of the outer fragment.

Exhaustive studies have been made to determine the cause or causes of non-union in the line of fracture of the neck of the femur. As in cases of non-union in the shaft of other bones, disturbances in the blood supply, interposition of soft tissue, general constitutional diseases, and lessened reparative power in old age have been considered as factors giving rise to this condition. The relation of disturbed blood supply to non-union has been the subject of much research, but the findings have been largely theoretical and not at all conclusive. The effect of constitutional diseases such as syphilis or diabetes upon bone repair has never been determined nor has it been proven that the reparative power of bone in the aged is any less effective in the neck of the femur than in any other part of the skeleton. Recent reports would indicate that the interposition of soft tissue in the line of fracture is not so uncommon. The frequency of this condition can be determined only through operation, but it is a definite complication which can occur and will prevent union. In one case in which there was considerable upward displacement of the outer fragment, the raw surface of the inner fragment was found to be completely covered with a large flap of thick capsule. But why seek for some unusual condition as a cause for non-union in fractures of the neck of the femur? Why should one not accept the same factors here as are accepted in other parts of the bones as the causes of non-union —the factors of poor apposition or reduction, improper fixation and insufficient time for proper repair in the fracture line? Perfect reduction and perfect fixation have the same relation to perfect union in fractures of the neck of the femur as in other fractures, but the physical structure of the neck of the femur in relation to weight-bearing of the trunk through the legs demands that a longer time be given for solid union than is required in the shafts of the long bones where angulation is not a factor. The healing of the fracture of the neck of the femur for complete weight-bearing is to be computed in months and not in days or weeks.

It may be stated as a dictum that whenever outward rotation of the outer fragment (the leg) persists in a fracture of the neck of the femur solid union cannot occur. This is due to the position of the raw surfaces of the two fragments, that of the inner fragment lying behind the neck of the outer fragment and in contact with periosteal bone and that of the outer fragment pointing

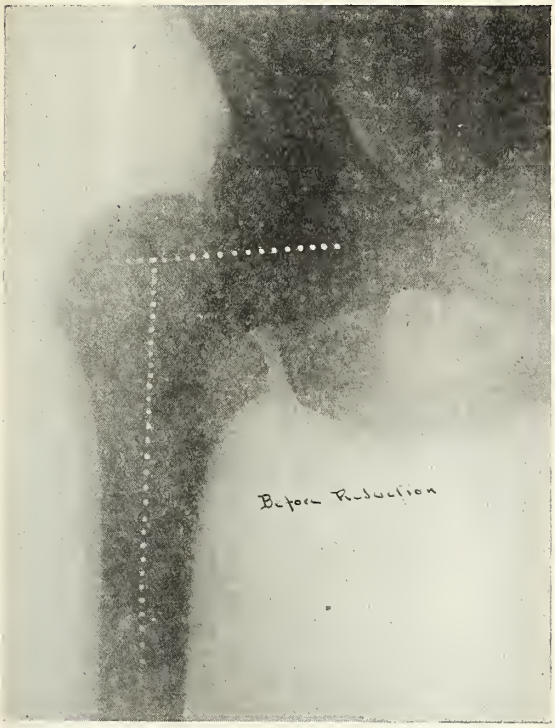


Fig. 1. Before reduction.

forward and inward and in contact with muscles and soft tissues. (Fig. 1.)

The treatment of a fresh fracture of the hip may be one of simple closed reduction or one of radical open reduction. Open reduction with fixation of the fragments by means of bone pegs or special nails may be permissible by those who have had special training in this type of operation, but before this method of treatment is to be accepted as that of selection it is yet to be proven that such a plan of treatment has a greater percentage of good end results than that obtained in a carefully executed closed reduction. For the general practitioner and for most surgeons the closed reduction will be more satisfactory.

Any plan of treatment must satisfy three essential factors, sufficient contact of the ends of the fragments without angulation (reduction), efficient splintage to maintain this contact without movement in the fracture line, and a length of time with perfect fixation to permit complete repair of the fracture. The use of sand bags does not correct the angulation and as a rule does not maintain reduction nor does this method prevent motion in the fracture line. The popular "Buck's" traction is but little better than the sand bags in that it does not correct the angulation nor give fixation of the fragments. The abduction splint of Bradford is very satisfactory but is not available in most instances.

Whitman gave a great contribution to surgery in his plan of treatment of the fracture of the neck of the femur, a plan which reduces the fracture, corrects the angulation, restores the full length of the leg and offers a type of splintage which maintains fixation for any length of time in a manner comfortable to the patient. This type of treatment is within the surgical field of any intelligent physician or surgeon and with a simple apparatus (Fig. 3) can be done in the home as well as in the hospital. The Whitman plan of treatment is applicable for all types of fractures of the hip. Advanced age is not a contra-indication to the use of this method. In the inter-trochanteric fractures one must be careful not to overcorrect the deformity as there may be but little, if any, adduction of the lower fragment. In the intracapsular type the inner fragment is, as a rule, fully abducted and it is impossible to overabduct the lower fragment as the impingement of the greater trochanter against the ilium limits the abduction range. In some cases the condition of the patient will contra-indicate any type of treatment for the first one or two days. The early proper reduction of the fracture and the early immobilization of the fragments through an efficient plaster of Paris splint will not only make the patient more comfortable and minimize the shock but will make possible a better prognosis for recovery and for function. The muscle spasm is much less, the position of the patient can be changed, the use of the bed-pan is not a dreaded ordeal, and with the use of the "no-back splint" the patient can sit up in bed and there is less chance for the development of bed sores.



Fig. 2. After reduction.

A general anesthetic is essential to obtain a reduction of the fracture. The writer uses intravenous doses of sodium amytal but any of the barbituric acid salts given either by mouth or by rectum will be satisfactory. In recent cases avertin

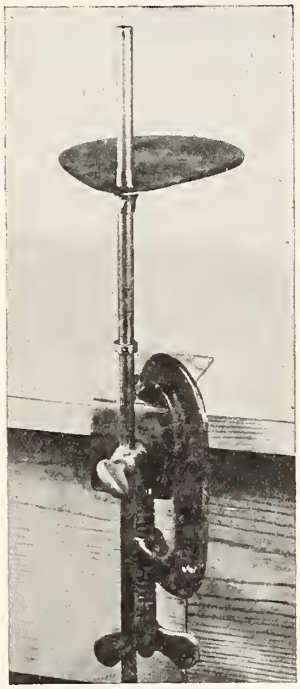


Fig. 3. Simple support for use in home.

per rectum has been used instead of sodium amytal. The dosage should be sufficient to produce a deep sleep to permit the preliminary arrangement of the patient on the table and later to apply the plaster of Paris splint. At the time of reduction of the fracture it may be necessary to have complete anesthesia through gas or ether, but this will be for a period of only five to ten minutes.

The patient is placed upon the fracture table and each leg secured to the foot piece. (In the home the simple support as shown in Fig. 3 can be used.) The well leg is abducted to full degree in order to fix the pelvis and also to act as a guide for the amount of abduction on the injured side. The fractured leg is then abducted to a position corresponding to that of the other side. At the time abduction is obtained the leg should be rotated into a neutral position to correct the outward rotation deformity. At this time some forward pressure should be made on the trochanter as the outer fragment will have a tendency to fall backward when reduction is made. As a rule there is but little upward displacement of the outer fragment but enough traction should be made to give an equal length to each leg. A light covering of the parts included in the plaster can be obtained by a single layer of sheet cotton or better by a stockinette. Avoid heavy layers of cotton. The bony prominences are to be protected by felt or heavy pads. Whitman in his original plan included in the plaster the entire leg and the trunk up to the nipple line. This has been modified by others to include the unaffected leg to the knee and carrying the upper edge to the costal border. A board from one leg to the other just below the knee will prevent the splint from breaking when the patient is turned and thus maintain the abduction position.

Following the suggestion of Thomson the writer in sixteen cases used a type of splint in which the back is removed. The affected leg is entirely encased in plaster in order to prevent outward rotation and the plaster is carried down to the lower fourth of the tibia on the other leg. The plaster is placed entirely around the pelvis and the abdomen but across the rim of the pelvis a board is incorporated in the plaster and another board is placed between the legs just below the knees forming a triangle in the splint with the apex above the pelvis. (Figs. 4, 5, 6.) After the plaster becomes hard the entire back is cut out to the gluteal folds leaving the sacrum uncovered. That part of the splint above the pelvic board is also cut off in order to allow the patient to sit up. A weight of about fifteen pounds is attached to the



Fig. 4



Fig. 5

board across the legs and run over the end of the bed. This prevents a slipping upward of the splint. With this type of a plaster splint the positions of abduction and neutral rotation are maintained, fixation in the line of fracture is efficient, the patient can be turned on the side or upon the abdomen and may also sit up in bed to an angle of at least forty-five degrees for reading, eating, and for rest. Pressure sores over the sacrum or skin disturbances due to urine soaked pads are prevented and the nurse has greater opportunities to keep the skin clean and dry. (Should a splint be used which has a back one may keep the parts dry by sliding in between the skin and the splint a



Fig. 6

piece of card-board such as comes with laundered shirts. This detail was worked out by an old lady eighty years of age.)

X-rays should be taken before reduction in order to determine the type of fracture and the amount of abduction deformity. A check up roentgenogram should be made shortly after reduction to determine the position of the fragments and at the end of four or five weeks another x-ray examination should be made to determine the process of healing as at this time it may be evident that non-union will occur and an open operation is indicated. In two cases the x-ray after reduction showed a satisfactory position but when the splint was removed at the end of three months there had occurred absorption and non-union.

The length of time for fixation in the splint is most important. Eight to ten weeks may be sufficient for intertrochanteric fractures but those through the neck require at least twelve weeks of complete immobilization. (Some surgeons feel that sixteen weeks is not too long.) After the splint is removed the patient should be kept in bed for at least four weeks and allowed to have active motion in the hip and knee. During this period it is absolutely essential that the leg should not be allowed to rotate outwardly either through the normal weight of the leg or through that of the bed clothes. This can be prevented by placing long sand bags against the outer side of the leg. After a month of active exercise in bed together with massage and other physiotherapy the patient may be allowed to sit up and later may be given crutches, but weight bearing should be guarded and allowed only to that extent which is not associated with pain. If there is difficulty in regaining motion in the knee, the adhesion may be broken up under a gas anesthesia. Twelve to eighteen months may be required to attain a final result. The general care of the patient requires constant attention. The urine especially in females may dribble back and cause excoriation of the skin over the sacrum. This occurred in two cases within twenty-four hours after injury. Hypostatic congestion of the lungs may occur and can be prevented by change of position and by deep breathing. The circulatory tone is maintained by systematic exercises with the arms. Stimulation is to be advised as indicated.

PROGNOSIS

The prognosis in a fracture of the hip should always be a guarded one. Death may follow within a few hours or days although there has been but little evidence of shock, or it may come at the end of several weeks during which convalescent period the patient has been in a satisfactory condition. The older the patient the higher the death rate, yet in this series several died whose age was near sixty and others lived who were past seventy-five, one patient being ninety-one. Seldom is there any sign or symptom at the time of the first examination which will be a guide in determining the prognosis. Even when a satisfactory position is shown after reduction one should remember that non-union may result from some cause and even when the later films show an apparent union the healing may not be sufficiently perfect to stand the stress and strain of weight bearing and even months later the symptoms of non-union appear. The end result of a fracture of the hip is not known until after a period of four to five years.

What is the cause of death in these aged patients who have had a trivial accident unaccompanied by severe trauma and resulting in a simple fracture of a bone without much displacement of the fragments? A study of this phase of the sub-

ject presents most interesting problems full of much speculation. Shock and pneumonia are the two causes given most frequently in the literature, but in this series only two cases were complicated with pulmonary pathology of a serious type and in each there occurred clinical signs and symptoms of an embolic infarction. Only one case presented the picture of a pneumonia, and that was of a mild type and short duration with recovery. In the two deaths with pulmonary complications one, age fifty, died the second day after two attacks of acute pulmonary oedema fourteen hours apart. The second case, age sixty-two, died in the twelfth week very suddenly with a history of "air hunger" when in apparently good condition. In those deaths which occur within one to four days and associated with severe shock the patients were past seventy years of age.

In the other deaths there has been a very definite cerebral change which has been interpreted as a cerebral anaemia. The onset of these mental changes come on from the fourth to the thirteenth week and are usually gradual. One of the first things to warn the surgeon is an expression of fatigue, the patients' greeting being that of "Oh, how tired I am." Later there may develop confusion, loss of memory, or even a well defined delirium which changes into a deep coma and finally death. There may be a terminal rise of temperature but otherwise no signs of infection. In two cases a partial paralysis of the upper extremity and in one case a facial paralysis appeared, the paralysis being of a spastic type. No change was noted in the blood pressure until late. Dr. Larue Carter, who has seen several of these cases, has added the following paragraphs upon this phase of the study:

"We have noted on frequent occasions a peculiar syndrome associated with bed-confining disabilities in the aged which is constant in its clinical manifestations and which almost invariably ends in death. It is typically seen in fractures of the neck of the femur, in individuals of seventy years or more with a moderate or advanced arteriosclerosis but with a compensated heart, competent kidneys, moderate hyper-tension, mental clarity and apparently in good physical condition. The shock of the injury and of the subsequent surgical manipulation are negligible, the patient being placed in bed with the application of some approved method of treatment. For the first few days or even weeks progress is satisfactory, temperature and pulse normal, nourishment and sleep sufficient, elimination ample, water balance normal, mentality alert and little or no pain. Within the first three or four weeks mild mental symptoms are noted. These symptoms may be drowsiness and lethargy with lack of attention and concentration or on arousing there is confusion, disorientation and amnesia with obstinacy and negativism, refusal to take fluids and food and with incontinence of bladder and bowel. The lethargy gradually increases until deep coma is reached. On the other hand the symptoms may be those of mild delirium, hallucinations, confusion, disorientation and unsystematized delusions of persecution with an increased psycho-motor activity with active resistance to the point of violence and destructiveness. These maniacal symptoms persist for a variable length of time, usually a week or two, gradually giving away to a deepening coma.

"The clinical findings in either the lethargic or delirious types are much the same. At first there is not any change in temperature, pulse or blood pressure in the excited cases but as the condition progresses the temperature rises to 106-108 degrees, the pulse becomes weak and thready and the blood pressure falls, in other words the thermocirculatory picture is that of a medullary collapse. Headache is absent, the pupils are contracted and sluggish, the eyeballs feel soft and there is a degree of enopthalmus. Paralytic signs are uncommon although they were noted in two cases and were spastic in character. Often a marked tremor in the hands and lips is seen. Cheyne-Stokes type of respiration may occur shortly before death. The whole picture is that of a profound cerebral disturbance of the medullary type terminating in death.

"As to the nature of this condition we can only speculate. Certainly arterial degeneration is the fundamental factor and the first thought is that it is a cerebral anaemia. Confinement in bed and curtailment of the usual muscular activities, the lowering of the blood pressure constantly depriving the brain of its normal blood supply, the low spinal fluid pressure, the soft eyeballs and the enopthalmus would support this theory. On the other hand there is not much, if any, change noted early in the blood pressure and in fact it may be increased in the excited cases. Water starvation might be assigned as a cause of the cerebral anaemia but in the onset the water balance is normal. The neck stiffness, the slow reflexes, the tremor and spastic paralysis point to a meningeal irritation such as would be seen in a generalized brain oedema of a circulatory or toxic origin but the lowered spinal pressure speaks against any marked degree of brain swelling. Could the condition be one of uraemia? The early urine and blood findings point against this though no doubt renal changes enter the picture as a terminal event.

"Much is to be learned regarding changes in body chemistry and body metabolism in the senescent period of life. It seems possible that with the curtailment of physical activity, the inevitable slowing up of all bodily functions (circulatory, digestive, and eliminative) fear and apprehension, loss of sleep, etc., may in some unknown manner alter the body chemistry or metabolism so that toxic by-products are formed and that these in turn attack the cerebral tissues producing a low-grade, non-inflammatory encephalitis which is in-

duced by the cerebral arteriosclerosis always present. Autopsy findings have not added much to the underlying etiology."

CONCLUSIONS

1. Fracture of the hip in patients past fifty years of age is a most serious lesion. Satisfactory end results obtained in only 50 to 60 per cent with a mortality rate of about 25 per cent. Non-union is not uncommon and results in considerable disability from loss of function and from pain.

2. Loss of muscle reflex protection must be considered as a factor in the cause of this type of fracture in the aged.

3. Improper interpretation of the x-ray may lead to the error of a diagnosis of impaction in the fracture line.

4. Poor reduction or failure of reduction of the fracture, inefficient fixation and insufficient length of time for healing are the chief causes for non-union. Disturbance in the blood supply to the head, or interposition of soft tissue between the fragments will lead to non-union even with proper reduction and splintage.

5. The Whitman plan of treatment is the most satisfactory as to end results and as to comfort of the patient. The "sand-bag" and Buck's extension methods should be discarded.

6. The "no-back" type of splint offers many advantages and is efficient.

7. Weight bearing should not be allowed for at least five months. The neutral position of rotation should be maintained for several weeks after the removal of the splint.

8. The prognosis should always be guarded. Cerebral changes are not uncommon in the fatal cases.

DEVELOPMENT OF MODERN MEDICINE[1]*

THEODORE ROOSEVELT
Governor General of the Philippine Islands

Members of the Philippine Islands Medical Association: It is a great privilege to be permitted to speak to you today. To me you gentlemen and your association personify the remarkable developments of our civilization. In recent years changes have come with such kaleidoscopic rapidity that we are apt to accept the great achievements of modern times without comment and without a full realization of how wonderful they are. This is particularly true in the case of medicine.

Only a comparatively short time ago modern medicine was practically unknown. The cures which today are considered usual would have seemed almost miraculous to our fathers. When we stop to think, we realize that it is not many years since the treatment of a patient was determined largely by omens and signs. People looked at the stars when they wanted to cure a sick man, or went out and got a frog skin or a bat's wing and tied it around his neck. Everything was considered supernatural.

During the past few centuries the citadels of the supernatural have been assaulted by science and have crumbled under the attack. Gradually we have come to the realization that supernatural is the wrong word. The word we should use is unknown-natural. For this great stride in knowledge the medical science deserves much of the credit.

A few centuries ago, thoroughly intelligent people gave as medicine remedies which would strike us as comic. The doctor's lore was a hodgepodge of superstition of every kind. Animals, stars, and herbs were mixed in an inextricable tangle. Three hundred years ago medicine had changed but little since the days of Hippocrates "when those afflicted with doubts and dismays" were supposed to be cured by touching a dead man. No one knew of the circulation of the blood. The heart was considered the seat of the affections, courage, etc. Even today we speak of a man's heart or a woman's heart in the same fashion. No one thought of dirt as having any connection with disease. They were far more concerned in looking at the planets when a patient was ill than in keeping him clean. Germs were unknown. If you had told anyone about them he would probably have said they were devils and that you were in league with them. Indeed, many of the pioneers in medical science suffered because the community at large thought they were in league with the devil and persecuted them accordingly.

Now all this has changed. The great scientists have turned their attention to natural problems and one by one these are being solved. Bacon discovered the genesis of cold storage which plays so great a part in feeding our people and keeping them healthy and, incidentally, he lost his life thereby. Harvey discovered the circulation of the blood. Walter Reed found the reason for yellow fever. So the tale runs down to our own times. Every year brings forth new and startling discoveries with their resultant benefits to mankind. I predict that, largely inspired by our work here, leprosy will soon be conquered.

I do not believe that we of today sufficiently realize how much we owe to the surgeons and doctors of modern times and to the inventions of even the last fifty years or so. At least two of my own family have had their lives saved by discoveries unknown in the time of their grandfathers. There is hardly a person listening to me who has not had some one in his family or some near acquaintance saved by modern medicine.

With all this great modern development it is surprising how much ignorance still exists, not only

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[1] Read at the opening meeting of the 30th Annual Session of the Philippine Islands Medical Association, December 13, 1932.

in the world at large, but here and in the United States. When I was a little fellow of twelve or thirteen I had a bad attack of pneumonia. My father was then President of the United States. I was at school and he came up with my mother to see me. The papers all chronicled his trip and the reason for it. As a result, nice kind-hearted people all over the country wrote to him and explained what to do. Two of the remedies suggested stand out in my mind. The first of these was to get a spotted toad, boil it for three hours, and then give the resultant broth to me to drink. The second was to catch and kill some ordinary rats, split them open, and use them as poultices on my chest. I think that each one of you will remember hearing of some remedies that, if not quite as grewsome as the above, are at least as ineffectual.

In the back eddies of the world modern medicine is still nearly unknown. A few years ago, when my brother Kermit and I were in Central Asia, we found a very old and primitive people. They had the oldest types of remedies, and charms and fetishes of every sort. One of the animals we hunted in the Tian Shan mountains, the Asiatic wapiti, has been largely exterminated by native hunters because his horns in the velvet are considered splendid medicine by the Chinese. We found fossils of all sorts were remedies for almost everything. One day I noticed one of my hunters cutting a tear duct from the eye of a dead stag. I asked him why. He explained to me that any woman who ate the tear duct would have a very large number of children. I stopped in apothecary shops in the plains of Yarkand. The remedies they had piled on their shelves made them look like a child's museum.

A very pathetic side of it all was the way the people flocked around us to be cured. Because of our modern hunting equipment, they thought we were "medicine men" of the first order. When we camped by some village the natives always brought us the maimed, the halt, and the blind in the belief that by some black magic we could cure them. Of course, nine times out of ten our very simple stock of explorers' medicine was thoroughly inadequate to the task. Often the miserable patients were decked out with charms and fetishes. The poor creatures believed we could cure their friends and relatives if we wished to do so. We had fathers bring their children to us. When we said there was nothing we could do, they went away and came back to us bringing all sorts of presents, with the idea that we could help if we wanted to, and perhaps presents or bribes might make us do so. Neither Kermit nor I know much about medicine, but often we would recognize the disease that some individual had. Sometimes this disease could have been cured with ease by any of our good doctors here, yet we knew that the individual would either die or, worse, lead a useless life of constant pain. A complaint not even considered serious in one of our hospitals is often a sentence of death to a Turcoman.

All this brought home to us very strongly the great part medicine plays in our lives. All this makes me deeply sensible of the value of this medical association to the community.

The medical profession is really, in its essence, philanthropic. It reflects both on the present and on the future. It reflects on the present in that it makes it possible for many to be properly treated and cured and lead happy, useful lives who might otherwise be in the position of those children we saw in Turkestan. In other words, it makes useful citizens for the Philippine Islands. This appeals to me more than almost any other aspect.

I think we have made too much of a fetish in modern times of simply preserving life. After all, it is not life itself that is all important; it is what we are able to do with life. I believe most strongly in a profession which has for its principal objective the fitting of humanity, particularly children, to grapple successfully with the problems of life. It reflects on the future in that, through the work it does, many new and valuable discoveries will undoubtedly be made which will save countless lives.

Here in the Philippines there has been done notable work. Our achievements in the study of leprosy are known throughout the world.

This year the legislature has taken a very progressive step. It has united all the health endeavors of the government under one head who will be an under-secretary in the Department of Public Instruction. Personally, I believe that eventually there should be a department of health with a member of the cabinet at its head. However, at this time, thanks to the reorganization bill of the legislature, we can practically accomplish all that could be done with a department. A golden opportunity lies in our hands.

The government intends to avail itself of the advice of you gentlemen of the Philippine Islands Medical Association and of your fellow-physicians of the Colegio Medico-Farmaceutico de Filipinas.

I have spoken to the presidents of both organizations and told them that, while I am Governor General, it will be my policy to ask the two associations to submit a list of names to me when the board of medical examiners is to be appointed or a vacancy thereon filled. I will then select gentlemen from that list. Furthermore, I have asked both presidents to submit as soon as possible suggestions and ideas covering the reorganization of the health activities of which I have spoken.

I believe in the medical profession, because its work is constructively patriotic. It helps and will help our people of the present to be sound, healthy citizens. It builds for the future, in that it not only saves the lives of many children, but also gives them the opportunity, through health, to have that chance in life of which sickness might have robbed them.

You gentlemen play a most important role. Your standing is high. Your ability to help is great. Do not for a moment forget that that means your responsibility is great also. Keep your standards untarnished and your honor unspotted. Maintain the splendid traditions of the service.

CARING FOR THE INDIGENT IN SHELBY COUNTY

SAMUEL KENNEDY, M. D.
SHELBYVILLE

Shelbyville is an industrial city of twelve thousand inhabitants, with about sixteen factories (largely furniture factories), most of which are closed, or running with only a small force and on short time. This has thrown probably eighteen hundred men out of work and of these about seven hundred families are being fed by the township trustee, which is being done by him at an expense of about fifteen hundred dollars per week.

The trustee has had for several years a contract with a local physician to take care of the poor of the township for fifteen hundred dollars per year. I understand that this sum has been raised this year to two thousand dollars. The local physician in charge of this work last year had fifty-six obstetrical cases for the township; he tells me that he had more work last winter than he could do. The members of the county society realized that no one physician could take proper care of this many people and resolved to do what it could to help out in this situation.

The Shelby County Medical Society, under the direction of Dr. J. E. Keeling, of Waldron, president, appointed a committee of five members to formulate plans to conduct a free clinic for the benefit of the indigent of Shelby County. This committee is composed of five members of the county society.

The committee met within a few days and selected a "Director of Clinics"; also they decided to divide the physicians of Shelbyville into groups of three each (this made five groups) for service at the clinics which were to be held at the Major Memorial Hospital. The basement of the hospital was fitted for this purpose, with booths for examinations, and everything necessary was provided by the management of the hospital. It is an ideal place for this kind of work.

The clinics were held all winter three mornings each week, Monday, Wednesday, and Friday. They began at ten-thirty a. m. and continued until all the patients had been cared for (sometimes lasting until two p. m.).

All prescriptions were taken to the local druggists to be filled.

At a meeting with the druggists they unanimously agreed to fill all prescriptions marked "Free Clinic," at cost. Mr. Frank Moore, the township trustee, agreed that the township would pay the druggists for the prescriptions written. This was, I believe, an ideal arrangement but it could not have been done with a less efficient trustee or one who would have refused to co-operate. Our trustee has done everything he could to make the clinics a success.

With a card-index system, a careful record was kept of every case; name, age, residence, diagnosis and treatment were recorded. In this way each group of physicians following up the case could know exactly what the diagnosis and treatment had been. Also each patient would, if he came to the clinic often enough, have the opinion of fifteen physicians as to his case. X-rays were made and laboratory work was done by the technician at the hospital. Wasserman examinations were sent to the state laboratory. A large number of patients have been taken care of; on many days there were more than forty patients. The clinics were continued throughout the winter from about November 1, 1932, until about May 10, 1933, at which time the number coming for treatment had been materially reduced, due largely to the fact that there is not so much sickness in summer as in winter and to the fact that most people are better able to care for themselves in summer.

The committee expects to resume the clinics on or about November first for the winter of 1933 and 1934, with a number of improvements. The experience gained from the clinics of last winter will materially aid us in formulating our plans for the future.

These clinics have, I am sure, been very successful both from the standpoint of the physicians and of the public.

There has, no doubt, been some abuse of the service given, but not very much. The chief complaint of some of the physicians is that a number of patients have come to the clinic with trivial ailments that did not need any attention. Also a few others came almost every clinic day when they did not need to do so. This has been true of a few and it has been suggested that we make a charge of, say, ten cents for every one coming for treatment. It is thought by some that this would eliminate this type of person. However, if this were done it would no longer be a "free clinic" and it would be a handicap to others who deserve all that can be done for them. This question, among others, will be decided by the committee before we resume the work in November.

ADDITIONAL WORK

Besides the "free clinics" outlined above our county society has for many months conducted a monthly tuberculosis clinic. This also has been held at the hospital under the supervision of several physicians especially interested in this work. They are held on the last Thursday in each month.

They have been very successful and have accomplished much good. They are held every month in the year. New cases are discovered and are properly taken care of. We are also making a serious effort to follow up these cases.

During the past winter the Indiana State Board of Health outlined, under the direction of Dr. Ada Schweitzer, a number of child health clinics for our county. This program, as outlined, called for child health examinations of children of pre-school age at every schoolhouse in our county, with the help of the various parent-teacher clubs. About the time these examinations were to begin the change was made in the State Board of Health, and this immediately upset all the plans that had been made by the former board. Our county society took hold of this situation and, with the cooperation of Dr. J. H. Hare, the new secretary of the State Board of Health, did the best it could on such short notice. There were only a few days for any sort of organization. Examinations were begun on April 21st and ended on May 25th. This is the work that was done in fourteen different days at fourteen schoolhouses in the county. It was done with the aid of twenty physicians (all members of the county society), Miss Grace Ewing (county health nurse), fourteen graduate nurses, and fifty-two others, members of the various parent-teacher clubs. Examinations were made of 276 children.

Boys, 130; girls, 146.

Marked C for one or more defects, 223; free from defects, 53.

Of the 276 examined the following had been vaccinated as follows: Smallpox, 8; diphtheria, 23; scarlet fever, 4; smallpox and diphtheria, 2.

T. B. contacts, 29; special cases for follow up, 48.

Examination Findings

The following is a resume of what was found by the examinations:

Teeth, requiring filling or extraction, 64; eyes, defective, 8; hearing, defective, 26; nose and throat defects, 145; heart defects, 4; chest defects, 14; skin diseases, 33; glandular defects, 46; orthopedic defects, 8; poor nutrition, 32; poor posture, 26; feet and legs, 21; abdomen, 10; genitalia, 45; circumcision recommended, 32; hernia, 9; unclassified, 19.

The examination of children of pre-school age will be much enlarged upon in the near future and we hope at some time within a few months to evolve a plan so that every child in the county can have a physical examination before entering school. Also we want to arrange for the vaccination for both diphtheria and smallpox of as large a number of school children as possible. We think these diseases can be entirely eliminated.

This work, in addition to the free clinics and the tuberculosis clinics, makes a large program, but in my opinion it will be accomplished by the Shelby County Medical Society.

LEUKORRHOEA*

Don D. Bowers, M. D.
Huntington

I have elected to discuss leukorrhoea of nonmalignant origin chiefly because, as a symptom, leukorrhoea is usually treated in a most unscientific and perfunctory manner. I have chosen it also because a most frequent form, although first described by Donné[1] ninety-five years ago, has heretofore been grossly overlooked; I refer to vaginal infection with Trichomonas vaginalis. It has been generally assumed that infection of the female genital tract with fungus organisms is of uncommon occurrence, and it is evident now that the rarity of this condition has been over-emphasized.

It is not my intention to be hypercritical of others, nor do I wish to claim any particular originality. I have drawn freely from the literature on the subjects of trichomonas and monilia infections and shall attempt to present what appears to be the concensus of opinion of recent investigators, and shall add some of my observations on these subjects.

It is important to emphasize the fact that for many years leukorrhoea has been considered one of the symptoms accompanying almost all diseases of the female genital organs. Even our modern text-books leave the impression that leukorrhoea is a vague symptom, accompanying an infective process which might be localized either above or below the vaginal cervix. We had come to regard leukorrhoea along with altered menstruation, bleeding, pelvic discomfort or pain, and irritability or dysfunction of the adjacent organs, namely the bladder and bowel, as a symptom of pathology in the reproductive organs of women and without any special localizing significance. Recently, however, investigators have pointed out to us the significance and evidence of some infective conditions of the vagina and have established the importance of leukorrhoea as a localizing symptom. I believe that it may now be stated as almost a certainty that leukorrhoea is practically always due to lesions of the cervix and vagina and rarely to disease in the upper part of the genital tract. Probably a few more or less infrequent conditions of the uterus such as certain types of fibroids may lead to some discharge, but the importance of endometritis and salpingitis in the causation of leukorrhoea is negligible. Plass[2] is of the opinion that "The former occurs only rarely, and the diseased tube probably does not discharge its inflammatory products into the lower tract."

* Presented before the annual session of the Indiana State Medical Association at Michigan City, September, 1932.

ENDOCERVICITIS

The most frequent cause of leukorrhoea is endocervicitis. Endocervicitis is usually the result of an old gonorrhea or an accident in the conduct of labor. Lacerations during an obstetrical procedure are usually followed by infection of the cervix of non-specific nature. Occasionally we may see cervicitis in virginal women suggesting that the cervix may be infected from a distant focus; this is rare, however. Leukorrhoea is the symptom of cervicitis and on inspection we may see the cervix as an enlarged hyperemic organ. Dilated glands, the so-called Nabothian follicles, appear along with ulcerated areas of erosion and eversion. Eversion results from the exposure of cervical mucosa by tears. Erosion results from the proliferation of mucous membrane upon the vaginal surface of the cervix. These infected areas are easily traumatized and may bleed upon the introduction of a speculum, thus arousing the suspicion of malignancy, and suggesting the necessity for biopsy. This type of disease does not respond well to local treatments, mainly because of the nature of the anatomical structure of the infected glands, and the most that can be expected from the tampon and douche is partial and temporary relief. However, linear cauterization with the fine wire nasal cautery as first described by Dickinson gives a very excellent result, destroying the infected glands and thus eliminating the source of the trouble. It must be emphasized that this procedure should include the destruction of the Nabothian follicles in order to be completely successful. The procedure is a minor one and with the cautery heated to a red heat the linear cauterization of the infected areas is accomplished. This procedure may be repeated, if necessary. The cautery treatment should be followed by a short period of observation.

It is doubtful whether it is wise to use the cautery for the control of a persistent and irritating leukorrhoea during pregnancy, although I have done so successfully. Plass[2] in a recently published article makes the statement that "the use of the cautery for the control of increased leukorrhoea during pregnancy is debatable; it may be done gently, but probably carries some risk to the continuance of gestation."

Extensive eversions and wide and old persistent lacerations occasionally demand surgical treatment, either a simple trachelorrhaphy, the Sturmdorf operation, or a modification of it.

GONORRHEAL INFECTION

The gonococcus has long been known to produce an infection of a specific type within the vagina and until the recent work of Davis[3,4], DeLee[5], Greenhill[6,7] and others on trichomonas, and Heard[8], Popoff[9], Plass[10] and others on monilia, the gonococcus was considered the only organism of importance in the production of a specific vulvo-vaginitis. Before the publication of these papers many women were thought to suffer from gonorrheal infection who in reality had a non-venereal parasitic infection. Many sought relief in extensive operative procedures who were suffering from a local vaginal infection. There is a very important and far-reaching class of pathological conditions affecting the vagina and two distinct organisms; the trichomonas and the monilia have already been isolated from these patients; probably more await identification.

About 100 years ago Donné[1] described a motile protozoan organism known as trichomonas. Dock[11] and Davis[12] in 1896 found the organism in the vagina of one woman, but did not know of its clinical significance. DeLee[5] in 1920 published the first clinical paper on the subject. This paper, published in the *Illinois State Medical Journal*, apparently did not arouse much comment or attention. Greenhill[6] on February 18, 1928, read a paper on this subject before the Chicago Gynecological Society and this paper was published in the *Journal of the American Medical Association* for December, 1928. It described what apparently was a specific infection of the vagina.

It is interesting to note that until 1928 observers were about evenly divided on the question of the pathogenicity of the fungus and in the *Journal of the A. M. A.* for September, 1922, Lynch[13] said, "There exists only circumstantial evidence of any harmful effects" and in conclusion he stated his belief that the fungus is a harmless invader.

Since 1928 hundreds of cases have been reported in the literature and the available evidence seems to point to the fact that the organism is the source of this type of infection. C. H. Davis[12] has studied the cultural characteristics and the effects of antiseptics on the organisms. The organism seems to be killed easily by ordinary antiseptics. Blood serum is an important ingredient in culture media for the organism, and this fact seems to compare favorably with the clinical experience with the infection in relation to menstruation, at which time symptoms are always exaggerated.

There are many unsettled facts with relation to the organism. The mode of infection is one, although there seems to be a similarity and perhaps identity between trichomonas vaginalis and trichomonas intestinalis which is an inhabitant of the intestinal tract of man. The concensus of recent reports on the subject by Davis[4], Hegmar[14], and Williamson[15] seems to be that the intestinal tract is the source of the infection and auto-inoculation the most plausible method of spread in women.

That the infection is not a rare one is evidenced from the records of a series of two hundred pelvic examinations made in my office upon women consulting me for pelvic complaints. There have been sixteen cases with trichomonas infection among them. Of these two hundred women with pelvic

disease about one in twelve had trichomonas infection. Of the same group there were eighty-two cases diagnosed cervicitis. The trichomonas cases varied from twenty-two to forty-nine years of age with the cases being fairly well distributed between these ages. There were two, ages twenty-two and twenty-five, who were unmarried and probably virgins; the remainder were married or had been married. Seven had had children. The seven childless might be interpreted and bear out the suggestion of relationship of this condition to sterility first suggested by Andrews[16]. The infection is evidently common during the years of menstruation.

A majority of the cases were women of clean personal habits, although it is my belief that lack of cleanliness greatly exaggerates the condition. Some of these women were the most fastidious in character. All were white women.

Every case presenting itself had a marked vaginal discharge, and this was the symptom for which each sought relief. The discharge had a bad odor and was creamy yellow or creamy white, occasionally appearing frothy or foamy.

The patient complains of vaginal burning and itching and the secretion is highly acid. The vagina appears intensely reddened and frequently red macular areas, and even small ulcerations appear, especially about the vaginal cervix. The patient will complain more during and following menstruation because of the decreased acidity of the vaginal secretion at this period, under which condition the organisms multiply more readily. The most intense tenderness to manipulation and examination may be present.

Diagnosis is made by hanging drop examination of the fresh vaginal secretion diluted by means of a small amount of salt solution. An ordinary cover slip may be used or a couple of threads may separate the edges of two cover slips with the specimen between. Under high power the organism is easily recognized, mainly because of its motility. The parasite is oval, about the size of a pus cell or a little larger, and smaller than a vaginal epithelial cell. The motility is produced by the vibration of flagella at one pole. If the patient has had a douche recently the organisms may not be found. The organisms do not stain by ordinary methods. According to those who have studied the parasite, culture is possible but difficult. There have been reports[17] of urinary infections, such as pyelitis with trichomonas, and the organism has been found in the secretion from the male prostate.

TREATMENT

Treatment is not as satisfactory as one would like it to be, as no specific has yet been produced, yet I have had satisfactory results with the method of treatment first described by Andrews.[16] This method depends upon cleanliness and mild antiseptics. Of all the procedures which I have used this one is the most productive of results. Others report good results with some of the other methods which I shall mention.

A few of these patients had had previous treatment mostly by the ordinary tampons and douches. Two had had dilatation and curettage. My experience leads me to believe that a patient who has a history of long standing, and has undergone active treatment without relief, probably is suffering from trichomonas infection.

An obvious necessity in the treatment of this condition is the application of some antiseptic to every bit of the mucous membrane of the vagina and cervix. I use the knee chest position and expose the vaginal surface thoroughly by means of a posterior retractor: with a head mirror, or a good light on the speculum, one may thoroughly inspect and apply the antiseptic to the entire vagina and cervix. The primary procedure I have used is a thorough scrubbing of the vagina and vulva with green soap, using a gauze square on a sponge forceps as in preparation for vaginal surgery. The soap is removed by sterile water irrigation and followed by irrigation with one to one-thousand bichloride of mercury which in turn is irrigated by sterile warm water. The entire mucous membrane is then treated with 10 per cent silver nitrate; one-half ounce of a 25 per cent ichthyol in glycerine is instilled in the fornix; and a tampon inserted with instructions for removal the morning of the following day, at which time a gravity douche consisting of ½ per cent of compound solution of cresol is taken. The patient returns on the second day and the scrubbing is repeated. The ichthyol solution is at this time omitted, the vagina is thoroughly dried by cotton sponges, and soda bicarbonate is blown into the vagina with an insufflator. This latter treatment is alternated with the ichthyol and glycerine instillations. There are usually three treatments during the first week, at the end of which time the patient is very comfortable. At menstruation the treatment is continued because it is during this time that the symptoms are apt to be exaggerated or to recur. The powder is insufflated at this time and one-half or one dram instilled in the fornix with instructions given the patient to take a warm cresol douche the following day, and each day alternating with treatments.

It has been suggested by Evans[18] that the patient instill an alkaline powder such as soda bicarbonate by means of number twelve veterinary capsules which may be placed in the vagina at morning and at bedtime after an alkaline douche.

It may be necessary in a very severe or acute case to administer treatments daily in order to control the patient's symptoms.

The patient is instructed as to the proper method of wiping the anal region, from before backward instead of vice versa, as is extensively practiced, and daily cleansing of the vulvar and anal regions is advised. Shower baths are preferable to tub

baths. Insertion of a capsule of alkaline powder is advised after coitus as the symptoms ordinarily are aggravated by this act.

It is only with every care taken in the observation of these cases, and with a great deal of energy and time spent in the treatment, that one can expect to get results. The results obtained for the patient depend entirely on the meticulous care exercised in the treatment by the physician, and upon the patient's co-operative efforts.

Many other methods of treatment have been suggested as mentioned by Plass[2], such as:

Acid douches—0.5 per lactic acid, or corresponding strengths of other organic acids. Lactic acid contraceptive jelly.

Drying by current of warm air from a hair dryer, or by packing the vagina with kaolin or some similar powder.

Cleansing with repeated douches.

Use of antiseptics such as methylene blue 1-8000 with glycerine.

Half strength tincture of iodine and 10 per cent boroglycerine.

Plass[2], already cited, states that "treatment is unsatisfactory." It is true that there are some infected who require a great deal of diligence. No specific medication has yet been produced. Yet with the treatment I have used and described, it has been my experience that all can be relieved and generally a negative hanging drop will be forthcoming in from one to two months. The relief from symptoms is accomplished in short order, however, and that is the important thing to the patient. There are sometimes reinfections after the patient has been cured: That is, after the patient has presented a normal looking vagina and cervix, is without symptoms, and when no organisms have been found several days after having received a douche.

MONILIA VULVO-VAGINITIS

Plass[10] has clearly shown that monilia vulvovaginitis is due to the organism which is recognized as the cause of oral thrush in the new-born. He has also shown quite conclusively that the newborn child obtains the infection as it passes through the birth canal of the infected mother.

Monilia vaginitis is predisposed by pregnancy and diabetes, when probably the greater acidity of the vaginal discharge favors the growth of the organism. Plass reports that eleven of sixteen pregnant women complaining of vulvar or vaginal irritation showed monilia infection, while nonpregnant patients complaining of the itching showed only eight positive monilia cultures out of thirty-three cases. In his series many monilia infections were associated with trichomonas infection. In this group of two hundred pelvic cases, three patients suffered from monilia vulvo-vaginitis; one of these was pregnant and two were diabetic. None were infected with Trichomonas.

The most predominate symptoms of monilia infection of the vagina are pruritis, burning, and irritation. The discharge is variable in character, there may be only a thin, relatively slight, watery secretion with small flaky particles suspended in it, or it may assume a thick, purulent, leukorrhoeal character. The character or amount of the secretion seems to bear no relationship to the severity of symptoms. The introitus and vaginal mucosa may be diffusely reddened or occasionally, as in one of my cases, may be patched with exudate as in oral thrush. One of my cases at first showed the entire vulva diffusely inflamed and oedematous with angry hyperemic and granular mucous membrane, with a very slight amount of thin secretion. She had evidently had the infection for two years and she was referred to me in her fourth month of gestation. It was necessary to control the burning, irritating distress of the patient with opiates, and hospitalization was resorted to in order to obtain the constant attention necessary to succeed in controlling the infection. Within ten days she was comfortable, was able to leave the hospital, and was delivered of a healthy babe at term without recurrence of symptoms. Smears obtained at intervals during the remainder of the gestation were negative. That is one and one-half years ago, and as yet she has not had a recurrence.

The diagnosis is easily made by smears stained by the Gram method, and the gram-positive fungi are recognized among pus cells and debris in conidia or spore form, and mycelia or thread-like filaments. The mycelial threads with their budding elements cannot be mistaken because of the branched and yeast-like character, but the conidia look somewhat like pus cells. Plass[2] states that diagnosis is possible in hanging drop preparation although I have not recognized the organism by this method. He also gives an excellent description of the culture on Sabouraud's media and the morphological characteristics.

The cultural and biochemical characteristics of the monilia organism are very clearly discussed by Stovall and Bubolz[19] who conclude that the species isolated from the vagina in cases of monilia vaginitis, namely Monilia albicans and Monilia candida, are the same species found associated with other diseases of the body, not only oral thrush but a multiplicity of disease processes on mucous membranes other than those of the mouth, throat and vagina.

Treatment as outlined recently is almost specific and one has no difficulty in controlling the infection. After the removal of the suspended secretion within the vagina by means of cotton pledgets, a generous application of 1 or 2 per cent aqueous solution of gentian violet is made through a speculum to the vaginal and cervical mucous membrane. The vulva and surrounding skin should also be generously painted with the dye. The patient is usually comfortable after the second or third application, but the treatment is repeated every day for

five or six days, then every two or three days for two weeks, after which time smears of the vaginal secretion are generally negative for the yeast organism.

Although leukorrhoea is a very common complaint of women, and even is taken as a matter of course by many of them, it seems unnecessary to warn physicians that they should not fall into the error of doing likewise. A patient complaining of leukorrhoea deserves a thorough examination so that she may be relieved of this troublesome complaint rather than having doled out to her the latest douche powder and going through life with a douche pan and nozzle as constant companions.

SUMMARY

Leukorrhoea is a frequent and troublesome symptom in women and is usually due to infections in the cervix and vagina and rarely if ever to pathology of pelvic organs above the cervix. Endocervicitis is the most frequent cause of this symptom and is best treated by linear cauterization. Trichomonas vaginalis vaginitis is more frequent than has been commonly supposed; it is a troublesome disease; its diagnosis is simple, being made easily by microscopic examination of a hanging drop specimen; and treatment is fairly satisfactory. Monilia vulvo-vaginitis is fairly common; it may cause a great deal of suffering; the diagnosis is fairly easy, as the organism is easily stained by the Gram method and easily cultured; and treatment is practically specific, as the disease responds very well to 1 or 2 per cent of aqueous gentian violet solution, applied locally.

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DISCUSSION

CLAUDE R. PETTIBONE, M. D., Crown Point, Ind.: I think the subject of leukorrhoea has been much abused during the past several years. A good many of us have either allowed our patients to treat themselves with douches, or have operated upon them perhaps unnecessarily. I think we should determine whether the leukorrhoeal discharge is specific or non-specific; whether it occurs in women who have had children or who have not; whether it is due to some metabolic disease; and whether we are dealing with a malignancy or a new growth.

My experience has been that leukorrhoea due to Trichomonas vaginalis is not very common in my practice. I have seen only two or three cases during the past three years, since this subject has become popular. Each case has occurred in an unmarried woman, with a history of persistence over a period of seven or eight years. I think it was this that made me suspicious that the condition might be something other than ordinary leukorrhoea.

The subject of endocervicitis, I think, should be touched on a little more fully. Practically 90 per cent of the women who have borne children have an erosion in the endocervix. Many of them get well of their own accord, but many develop a chronic discharge. I think every woman within four weeks after delivery should be examined, whether she has any symptoms or not, and she should be treated if she has any disturbance of the mucous membrane. The ordinary use of silver nitrate will clear up most of the usual cases of endocervicitis. In the cases that do not clear up under the usual measures, I have discontinued the linear cauterization and have substituted the method of electrocoagulation. I have done this because it is a simpler procedure, requires no anesthesia or hospitalization, and I believe that it destroys abnormal mucous membrane much better than the linear cauterization. In a few cases I feel that linear cauterization is preferable. In the more extensive cases, I think, none of these methods will help.

As to leukorrhoea in children, some of us do not see much of this. I have seen a good many cases during the past several years for it has been my privilege to examine all the children in the Lake County institution. There we find that this infection in children is not specific at all. Many of these children are undernourished, underweight, subject to infections of all types, and I have wondered whether they were not patients who were suffering from some deficiency disease. I think they have been, for the simple use of cod liver oil and calcium has cleared up many of these cases.

ELMER G. KOEHLER, M. D., Elkhart: Especially commendable was that part of Dr. Bower's paper devoted to the vaginitis associated with the infestation of the Trichomonas vaginalis. This type of vaginitis until recently has not received the attention it deserves. The pathogenicity of the Trichomonas vaginalis is still unproven. Experimentally it can not successfully be transplanted from one host to another. It does not always produce a vaginitis even though the organism may be found in great numbers in the vaginal secretion. Recently Hessaltine reported that the diplococcus frequently associated with a Trichomonas infestation is the real etiological factor of the vaginitis. However, it is generally observed that improvement closely parallels the disappearance of the Trichomonads from the discharge accompanying Trichomonas vaginalis vaginitis.

While the first American contribution to the literature appeared in 1928 (DeLee), this type of vaginitis has been the subject of research and study for almost one hundred years. Countless cases are cited which failed to respond to the routine treatment of vaginitis or major surgery. Even with the diagnosis established the condition often proves refractory to most accepted methods of treatment. Some cases respond quickly, while others reluctantly yield after months of continuous therapy. In the past few years I have had two cases which were treated continuously for over a year. No patient is discharged until she remains symptom free for four months, and until a hanging drop of her vaginal secretion has been Trichomonad free after four consecutive menses, during which time all treatment has been suspended.

The organism should be sought routinely in the hanging drop, in all cases of leukorrhoea as well as in those reporting for prenatal care. The Trichomonas vaginitis is found in 10 to 30 per cent of these patients, most frequently in the pregnant woman. Treatment is carried out in the pregnant and non-pregnant. Trichomonas infestation warns the accoucheur against doing a routine episiotomy or prophylactic forceps or any unnecessary vaginal manipulation during the delivery as the incidence of infection of a surgical wound, or the birth canal in general, is decidedly higher when this organism has been found prenatally. Prenatal treatment minimizes this morbidity.

An infrequent but characteristic finding in this type of vaginitis are the shallow ulcers described by Kleegman. They are generally observed in the vaginal vault or on the cervix. Their borders are sharply demarcated and their surface raw and hemorrhagic. They are distinguished from the ordinary "cervical erosion" in that the ulcer is not continuous with the mucous lining of the cervical canal. These ulcers respond to routine local therapy, only rarely requiring cauterization.

It is important to appreciate the fact that this infection is entirely limited to the vagina. The probability of the vaginitis extending into the cervix, uterus, and tubes is remote. The treatment, to be successful, need only be applied to the vagina.

In closing I wish to call your attention to one rather important fact that must be kept in mind to prevent a grievous mistake being made in the laboratory diagnosis. A smear of the discharge, especially if it is frothy, will undoubtedly contain some very suspicious looking diplococci. Proper staining and careful observation will differentiate this diplococcus from the Neisserian organism. It is generally accepted that gonorrhea seldom precedes or co-exists in a Trichomonas vaginitis. A diagnosis of a concommitant venereal disease should therefore be made guardedly, lest we err, and thereby cause someone to bear the stigma of gonorrheal infection.

The treatment is logically based on the characteristics of the Trichomonas vaginalis. This organism is thermo-labile, it is killed by dehydration, acids and alkalis, and most of our standard antiseptics. The difficulty is to overcome the mechanical problem of thoroughly treating every hidden recess of the vaginal canal, and to combat the influence that menstrual flow has in fostering recurrences. Failure to treat the patient daily during menses will prolong the therapy indefinitely and is the most common cause of failure to obtain a permanent cure.

SURGERY IN ITS RELATION TO DIABETES MELLITUS*

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Of the total population of the United States it has been estimated[1] that approximately 1 per cent suffer from diabetes mellitus. Because of the improvement in the care of diabetics during the past decade, these patients now live a longer, more useful, and less burdensome existence. Moreover, as more patients with diabetes live to an older age, more and more of them develop conditions requiring surgical intervention. Not only is this group of patients liable to every surgical disease to which the rest of mankind is liable but also these patients are prone to develop degenerative changes and complications which are more or less dependent on their specific type of disturbed metabolism. They are particularly susceptible to two special surgical diseases, namely, gangrene (chiefly of the lower extremities), and infection (mainly in the form of carbuncles of the neck).

The chief interest of the surgeon is in the degree of the influence of diabetes on surgical treatment and prognosis. Joslin[2] reports a mortality of 9.3 per cent in 548 operations during 1923 to 1927, the first five years of the insulin era. In the three years, 1928 to 1930, in 580 operations, there was a mortality of 5.9 per cent. Bazin[3] is of the opinion that surgical treatment and prognosis is

* Read before the Indianapolis Medical Society, November 22, 1932.

influenced very little, if at all, by diabetes and bases his opinion on results obtained at the Montreal General Hospital in 1929. He reports a mortality rate of 2.41 per cent for all operations and a rate of 2.74 per cent in seventy-three operations on those having diabetes. Such favorable results can be secured only when full use is made of all available adjuncts for the proper management of diabetes.

Unprepared a diabetic is a poor risk in any kind of surgery. Properly prepared, other things being equal, he is almost as safe a risk as his non-diabetic brother. Certain factors appear to increase the surgical risk of all diabetics. Some of the causes usually given for the apparent hazards are fallacies while at least one is a secondary cause. In the first place, the majority of diabetic patients are well above forty years when operated upon and may already be in a state of general decline, or they are prematurely old because of early degenerative changes of the blood vessels. Advanced age increases the operative risk in any group of patients.

In the second place, opinions are that when diabetes is controlled, the defense mechanisms of the individual are normal. It is primarily the aforementioned degenerative changes occurring in diabetics which render their tissues more susceptible to infection. The vascular changes, dryness of the skin with its lack of oils and its tendency to crack, predisposes to surface infections. Conversely, the functional insufficiency of the pancreas is increased by infection. Hyperglycemia and depletion of the alkali reserve follows unless controlled by adequate doses of insulin. It is probable that the disturbance of the acid-base balance with an alkali deficit is a factor more important, predisposing to infection than merely the hyperglycemia. Foster[4] states that if surgery is performed on a patient with a blood sugar higher than 350 mgm. and a plasma bicarbonate lower than 35 volumes per cent sepsis is most likely to result. Delayed healing and sloughing occur also, when the blood sugar level is higher than normal.

Surgical operation may raise the level of blood sugar, and cause dehydration and acidosis with the production of an alkali deficit. Proper preparation and management to a large extent can overcome these difficulties. The surgery of diabetes must not be lightly undertaken and the importance of the preparation of the diabetic cannot be stressed too strongly. His safety is not a matter of chance. It depends upon the necessity of vigorous, unceasing attention to detail, upon a preoperative care almost mathematical in its exactness, upon post-operative care equally scientific, and especially it depends upon the close co-operation of the internist and the surgeon. Delay of united action with the uncontrolled diabetic leads only to increased mortality. As a matter of fact, it is chiefly to the internist that the safety of diabetic surgery is due. Except that promptness of action and absence of trauma are more imperative than usual, surgical principles remain surgical principles.

Finally, in appraising the diabetic as a surgical risk, we must bear in mind that he is prone to develop certain secondary changes which of themselves increase the operative risk. Senile arteriosclerosis producing its characteristic organic vascular, cardiac, renal, and cerebral changes appears, on the average, ten years earlier in the diabetic than in those not having diabetes. These alterations of the myocardium, blood vessels, and kidneys, so often concomitant with the diabetic condition after the fourth decade of life, are of utmost importance in considering the diabetic from the surgical point of view. They must be borne in mind constantly and should influence our judgment to the same degree as when found in people without diabetes.

The indications for surgery in diabetics, as in all other patients, are of two general types, those of urgency and those of election. Urgent surgery is just as urgent in the diabetic patient as in any other but usually it is not quite as immediate. Unnecessary delay is never advocated but it is imperative to use sufficient time to learn and to combat actively the existing diabetic conditions. This fortifies the individual against the additional burdens his already altered metabolism will be called upon to bear when subjected to the added strain of any operation. The pre-operative treatment should attempt to establish the control of the blood sugar level, to add to the glycogen storage of the liver, to secure the disappearance of ketosis, and to supply a sufficient quantity of fluids.

In emergency the surgeon should know that the index of the carbon dioxide combining power of the blood measures the degree of acid intoxication. He should learn the concentration of the blood sugar to know how freely insulin and glucose should be used. Knowing these he should apply the specific therapeutic measures for the two rapidly moving pathological processes, namely, the acid intoxication and the acute surgical condition.

During the operative procedure it is imperative that respect for tissue be employed at all times. Hemorrhage contributes to shock and both contribute to ketosis. Following the operation repeated examinations of the blood sugar levels determine the amounts of insulin and glucose to be used. Adequate quantities of physiologic solution of sodium chloride given by the venous route are essential to satisfy the fluid requirements.

In a similar manner, considered from the diabetic point of view, surgery of election may be carried out in the diabetic, properly prepared and controlled, with the same assurance as in the non-diabetic. We have come to agree with Lord Moynihan that it is not the part of wisdom to permit the patient to die of the disease which can be remedied by surgical measures, or to live with it for that matter, merely because he happens to have something else the matter with him.

ANESTHESIA

For the treatment of gangrene or infections of the lower extremities, spinal anesthesia involves less shock and does not affect the carbohydrate metabolism. Nitrous oxide and oxygen or ethylene and oxygen are preferable for the treatment of carbuncles or conditions where complete relaxation is not essential. For those conditions requiring relaxation the writer prefers local novocaine anesthesia, if necessary, supplemented by a combination of nitrous oxide, oxygen and ether or by ethylene, oxygen and ether.

GALL BLADDER DISEASE

Surgical procedures designed to improve the functional insufficiency of the pancreas have a very limited field. DeTakats[5] found by animal experimentation that when the tail of the pancreas is isolated or ligated the acini degenerate and become sclerotic while the islands of Langerhans undergo hypertrophy and hyperplasia not only of the isolated portion but also throughout the entire organ. He has performed this operation on two children having diabetes mellitus and felt the method had possibilities.

The left suprarenal gland was denervated by Donati[6] in a clinical case of diabetes. From the results he concluded that when the elaboration of adrenalin is decreased the deficiency of insulin secretion by the pancreas is compensated. Perotti[7] questions these conclusions. The effect of unilateral suprarenalectomy is temporary because of the compensatory hypertrophy of the remaining suprarenal gland.

Some years ago, Mayo Robson[8] noted the relation of infections of the gall bladder to the production of diabetes and felt that the early removal of the diseased gall bladder might avert the diabetes. Bowen[9] and his co-workers state that autopsy records reveal but a slightly higher incidence of gall stones in diabetics than found at routine post-mortem examinations. There are others who could find no relationship between the incidence of biliary tract disease and diabetes, but some workers are convinced there is such a relationship. It cannot be doubted that an occasional cholecystitis precipitates a mild degree of diabetes. It is the opinion of the writer that, if possible, a diseased gall bladder should be removed. Other focal infection processes probably have a similar bearing, and questionable teeth, tonsils, and even an appendix may be eliminated to guard the tolerance of diabetic patients.

SO-CALLED DIABETIC ACUTE ABDOMEN

The so-called diabetic acute abdomen,[10] occurring with severe ketosis in the precomatose state, is manifested by vomiting, abdominal pain and tenderness, and vague muscular rigidity. With an acute intra-abdominal lesion, the pain usually precedes the vomiting; in the diabetic acute abdomen the vomiting precedes the pain. Leucocytosis may occur with ketosis and is of no assistance in differential diagnosis. An increased temperature is unusual with acid intoxication alone. In impending coma there is an indefiniteness in the physical signs and the general disturbance is out of proportion to the findings. The proper procedure is determined largely by the level of the alkali reserve and the degree of hyperglycemia of the patient.

CARBUNCLES

Carbuncles and other localized abscesses should be treated at once by surgical incision and drainage. For small carbuncles the gridiron incision of Maes[11] is useful. For large, painful carbuncles the writer prefers, if possible, complete excision. This quickly reduces the absorption of toxic material and markedly lessens the pain.

GANGRENE

Diabetic gangrene is a senile gangrene with an onset occurring about a decade earlier than in the non-diabetic. The rule is that it develops in the neglected diabetic patient. Joslin[2] remarks that if 90 per cent of diabetics could be persuaded to wash their feet carefully each night, 90 per cent of gangrene would disappear. The rigid avoidance of the slightest trauma to the extremities is imperative. At the first sign of injury or infection the diabetic patient should be instructed to consult his physician and never to attempt home remedies.

The fifth and sixth decades are the danger periods for gangrene. At the Charity Hospital in New Orleans, Lemann[12] found that under 40 years the occurrence of gangrene was negligible while it occurred in 31 per cent of the diabetic patients over 60 years. He noted that the percentage of diabetic patients having gangrene varies from 21 per cent in 228 negro patients of Charity Hospital, to 3 per cent in 3,000 patients of Joslin in Boston. Eliason[13] states that one-fifth to one-fourth of all diabetic patients die with gangrene. In the pre-insulin era, in twenty different series, for gangrene there was an average operative mortality of 34.04 per cent.[14] In nine separate series since the use of insulin the average mortality is 12.7 per cent. Of 281 operations reported by McKittrick[15] the general mortality was 11.6 per cent. He did 119 major amputations for conditions due primarily to arterial insufficiency. In this group the mortality was 17.6 per cent, and 10.5 per cent in nineteen amputations done primarily because of infection.

In treating the gangrene of diabetes it is essential, as in other fields of surgery, to individualize the patients. The surgeon who, versatile in expedient, selects the procedure best adapted to the case in hand should have the best mortality record. All diabetic patients with gangrene of the extremities have advanced senile arteriosclerosis. Most cases of gangrene begin with pain. Pain in the legs, cold extremities, numbness, and cramps occurring at night, are premonitory symptoms and should be a signal for the institution of preventive measures. Later the ischaemia is more marked with severe pain and sensations of constriction and during the

day intermittent claudication may occur. Arterial pulsation usually ceases first in the dorsalis pedis artery and later in the posterior tibial and popliteal arteries.

In the opinion of Lewis it is advisable to relieve the severe pain of the lower extremities that accompanies the ischaemia, by injecting the sciatic nerve with 50 per cent alcohol. Moreover, Pearse[16] points out that by the investigations of Halsted, Brooks, and Holman it has been established that if occlusion of a large artery is accompanied by ligation of its companion vein it results in a lower incidence of gangrene, an increase in functional capacity, an increase in intravascular arterial and venous pressure, and probably an increase in the functional efficiency of the capillaries. Of thirty-one cases studied by Pearse, approximately 50 per cent were benefited while the remainder were unimproved. Certainly, in properly selected cases, vein ligation is justified. Subsequent amputation, if necessary, may be done.

Dry gangrene is often self-limiting and patients with this form not too far advanced sometimes entirely recover with adequate medical treatment, without surgical intervention. Surgery, when necessary, should be conservative. The absence of sepsis and the ability to control the diabetes allow the surgeon to treat dry gangrene as in the nondiabetic. Infections present but not extending, as with an infected toe or other localized infection, should have similar treatment. This comprises standard surgical treatment of the local processes, such as debridement, incision and drainage, elevation of the extremity, the use of dry dressings and mild heat, preferably the electric pad, exercises designed to stimulate the circulation and, in addition, the control of the metabolism. It is the opinion of the writer that only a minimum of wet dressings should be used to avoid maceration of the tissues. Dakin's solution is preferred when such dressings are necessary.

With a small localized infection, such as an infected toe, portals of entry to the system are provided. Infection, accompanied by inflammation and exudation, causes still further pinching of the blood supply with consequent tissue necrosis.

One should be constantly alert for the appearance of constitutional symptoms with febrile reaction. Evidences of a general sepsis call for more drastic treatment. In conditions which are due primarily to local infection, in which the pulse of the arteries can be felt and the foot is warm and of good color, local operations are usually successful and amputation is unnecessary. Drainage of localized abscesses is imperative. Dorsal drainage of the foot is most effective, for attempts to drain in the plantar surface usually fail. With an arterial pulse present and the foot warm, the amputation of toes may be done safely for gangrene, osteomyelitis, or recurrent ulcer.

Major amputations for diabetic gangrene are to be considered as emergency life saving procedures, carried out in the most expeditious and efficient manner possible. Determination of the degree of occlusion and the efficiency of the collateral circulation is not easy. The most important factors indicating the circulatory condition of the foot are pain, the appearance and temperature of the foot, and the pulsation of the dorsalis pedis artery. Pain in the calf or sole of the foot suggests failing circulation. Severe pain with the leg at rest indicates arterial insufficiency with a poor prognosis. A foot with failing circulation appears dead when elevated and becomes dusky or red and shiny when dependent. A sharp change in the temperature at some point on the leg means failure of the circulation.

The positive indications for operation as remarked by Joslin[2] are: (1) the presence of the signs of a rapidly spreading infectious process; (2) the presence of a virulent infection with signs of septicemia or severe toxemia; (3) the presence of a diabetes that can no longer be controlled by frequently repeated doses of insulin and proper dietetic management. Operation is performed when any of these indications are noted. Without these, time is allowed for careful observation and adequate preparation.

The major premise of the old surgical law of Heidenheim is that amputation should be done above the knee routinely, the reason being that primary healing is more likely to occur in that location, for there the collateral circulation is more satisfactory. Moreover, it can be accomplished quickly and with the least loss of blood, and the patient can be out of bed in a few weeks. These two arguments, however, are against it: (1) in all amputations the mortality rises in direct relation to the nearness of the point of amputation to the trunk; (2) it is seldom possible to fit an artificial limb satisfactorily above the knee because leverage to manipulate the leg is lacking.

Some surgeons prefer the Gritti-Stokes amputation. It is usually satisfactory both as to healing and weight bearing. It is not the operation of choice when the surgical risk is great and it demands a more prolonged procedure with a longer period for anesthesia. The writer feels with Maes[21] that the old amputation of Kocher at the site of election is usually the amputation of choice. However, in extreme cases the most radical treatment may be the most conservative. The conditions may be of such seriousness as to demand a midthigh amputation and in the rare instance even a guillotine operation. Except in the guillotine amputation the use of the tourniquet should be avoided for it predisposes to thrombosis.

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DISLOCATION OF GLADIOLUS BEHIND MANUBRIUM STERNI

(CASE REPORT)

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LAFAYETTE

Recently I was called to the hospital to see a young man, age seventeen, with an injury to the front of his chest. He gave a history of receiving a blow over the sternum a few hours previously, while playing baseball. As he was sliding into a base, he either struck the knee of the opposing player with his chest, or was tagged in the sternal area with the ball; he was not sure which happened. He had sudden severe pain in this area and difficulty in breathing because of pain in the region of the upper sternum and left side of the chest. He also mentioned that he had this same area injured slightly about ten months previously in football, but received no medical attention and had only slight discomfort in this area at times while playing basketball during last winter.

I found him lying on his back with a pillow under the upper dorsal area of his spine and in acute pain with each movement of respiration. A depression below the manubrium, about three-fourths inch deep, was visible and palpable. A diagnosis of dislocation of gladiolus behind manubrium was made. Preliminary x-ray was not made because of the visible distress he was suffering.

He was given nitrous oxide anesthesia and an attempt was made at reduction by extension of the dorsal spine and pressure upward on the manubrium, but this was unsuccessful. A heavy cork-screw and a sharp toothed retractor and scalpel had already been sterilized. The front of the chest was shaved and prepared at once and a small stab wound was made over the gladiolus one inch below the site of injury, and the cork-screw was then turned into the gladiolus. The two-toothed retractor was then stabbed through the skin into the lower end of the manubrium and reduction was easily accomplished. Following this, a cross clavicular splint was worn for four days and the front of the chest was strapped with adhesive. He was immediately comfortable on awakening. X-ray the day after reduction, in profile and antero-posterior views, showed good position, and showed the separation to have been at the junction of the manubrium with the gladiolus and no fracture of ribs, or other bony structure of the chest. He made an uneventful recovery.

In reviewing the literature for several years back, I have found one reference to this type of sternal injury. Campbell, in Dean Lewis' *Practice of Surgery*, mentions dislocation of gladiolus anterior to manubrium only. R. C. Pendergrass, in the *Journal of Radiology*, November, 1929, describes a case of fracture of manubrium with posterior bowing, associated with compression fracture of the fourth thoracic vertebra. E. Pazzi, in the *Archives di Radiology*, July and August, 1926, describes the method of demonstrating by x-ray anterior dislocation of gladiolus on manubrium. Rexwald Brown, of Santa Barbara, California, in *Surg. Clinics of North America*, October, 1931, describes reduction of anterior dislocation of gladiolus on manubrium by extension of spine and traction upward on shoulders. D. R. Knapp, Kerrville, Texas, in *J. A. M. A.*, October 1, 1932, describes a case similar to this one with dislocation of corpus behind manubrium and with spontaneous reduction of the dislocation.

I present this as an unusual type of injury to the sternum and an effective and simple method of reduction of the same. It gives an efficient type of skeletal traction and obviates the necessity of a definite open operation.

(Three papers from the Mayo Clinic, presented before an Indiana University Seminar, are published in this issue. Three remaining articles will appear in the August number.)

SOME RECENT CONTRIBUTIONS TO KNOWLEDGE OF CORONARY DISEASE*

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The last decade has seen many additions to knowledge concerning coronary disease. Spalte-

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holz, Gross, Whitten and Campbell have greatly extended knowledge of the anatomy of the coronary circulation. The distribution of the branches of the right coronary artery to the basal portion of the left ventricle described by these authors has not received the attention it deserves, and the result has been failure to appreciate the frequency with which that portion of the left ventricle may be the site of infarction. The work of Whitten disclosed striking variations in the structure of the coronary arteries, depending on whether they are distributed to the right or the left ventricle. Branches of either the right or left coronary arteries going to the left ventricle leave the main trunks at right angles, penetrate the myocardium, and when they reach the endocardial surface turn at right angles, ending in a mass of fine arterioles. This has the effect of fixing the main trunks at the points of origin of the penetrating branches. When arteriosclerosis occurs, with resultant lengthening of the vessels, it leads to more or less angulation of the main branches at the points of fixation. This, together with the disproportionate degree of arteriosclerosis that occurs about the mouths of these penetrating branches, makes for greater narrowing at these points and increases the liability to thrombosis of the main branches.

On the other hand, the smaller branches of the right coronary artery, going to the right ventricle, spread out in the same plane as the main divisions from which they arise, and these small branches anastomose freely. This may be one explanation of the almost total absence of acute infarction in the right ventricle.

Gross expressed the opinion that with advancing years there is increasing impoverishment of the circulation through the right coronary artery, as compared with that through the left. Whitten's studies did not support that view, for he wrote, "The portion of the right coronary artery which supplies the left ventricle keeps pace in its vascular development with the left coronary artery in successive decades." Certainly if myocardial infarction can be considered as an index of the inadequacy of the coronary circulation, the overwhelming frequency of its occurrence in the left ventricle indicates failure of the circulation to the left ventricle with advancing years rather than failure of the circulation of the right ventricle.

Study of comparative anatomy indicates that the presence of coronary arteries is associated with the development of a cortical myocardium. In the lower animals the blood circulates in the intratrabecular spaces, through the whole thickness of the cardiac walls. Higher in the animal scale, in reptiles, the inner trabecular part of the myocardium retains a thebesian, sinusoidal circulation, while there is a definite coronary circulation to the cortical portion of the wall. There is free communication between these two systems of circulation. In the rabbit, the thebesian, intertrabecular circulation is much reduced, but it retains its connections with the coronary capillary system, and persists as an integral part of the adult myocardial blood supply. It is not surprising, therefore, that Wearn and his co-workers have been able to demonstrate in man communication of the coronary circulation with the chambers of the ventricles, either by way of the thebesian vessels or by means of coronary capillaries communicating directly with the ventricular chambers. Cases of bilateral occlusion of the ostia of the coronary arteries have been reported. The occlusions presumably had occurred gradually, and probably had existed for some time prior to their discovery. It is apparent that in such cases the circulation to the heart had to take place by way of the thebesian veins, through their connection with the coronary circulation, or possibly by backflow through the venous channels from the coronary sinus.

Besides the thebesian circulation, there is a variable degree of precapillary anastomosis of the coronary arteries. The coronary arteries are no longer considered to be strictly end-arteries. The degree of anastomosis appears to have individual variation, and on this account it may be assumed that some persons are inherently endowed with a coronary circulation which is little able to cope with acute closure of a coronary vessel. The degree of anastomosis tends to increase with advancing age, and that may be one reason why fewer persons more than seventy years of age die of acute coronary occlusion than those of an earlier age. The rate of obliteration of coronary vessels also plays an important part in the extent to which anastomotic channels develop. The studies of Oberhelman and LeCount may be interpreted to mean that in normal hearts in which there is a negligible amount of anastomosis of the coronary vessels, and in which the arteries are essentially end-arteries, sudden occlusion of an artery is likely to result in sudden death. In hearts which are fairly normal, and which possess rich collateral circulation, sudden occlusion of a vessel may be well tolerated, may lead to infarction, and subsequently to healing by fibrous replacement. In hearts with slow development of sclerotic narrowing, abundant coronary anastomosis is likely to occur, and it is in this group that sudden coronary occlusion is best tolerated. As Benson remarked, "It must be concluded, then, that arteriosclerotic narrowing of the coronary arteries as related to thrombosis of these vessels, is not an unmitigated evil in that it gradually prepares them for the catastrophe that is to come."

It is generally accepted that angina pectoris is associated with disturbance of function of the coronary circulation. The hypothesis that angina pectoris has its origin in the aorta has been largely rejected. Numerous experimental observations indicate that angina pectoris is the result of anoxe-

mia due to a blood supply insufficient for the needs of the cardiac muscle for the moment. This insufficiency may result from narrowing of the coronary vessels, from reduced oxygen-carrying power of the blood as in pernicious anemia, from decreased coronary flow and cardiac overload as in paroxysmal tachycardia, or from temporary cardiac overwork, possibly combined with some coronary disease, as in hyperthyroidism.

One of the assumptions of a few years ago was that myocardial infarction not infrequently involved the right ventricle, and this led to the attempt to distinguish infarction of the right from that of the left ventricle on clinical grounds. Studies made by Parkinson and Bedford, and those I made with Whitten and Ball, have shown that myocardial infarction is practically confined to the left ventricle.

Another erroneous conception current in pathology until recently was that coronary occlusion usually involved the anterior descending branch of the left coronary artery, and in consequence the anterior apical portion of the left ventricle was considered the chief site of infarction. This belief was crystallized in the statement that the anterior descending branch of the left coronary artery was "the artery of coronary occlusion." Ball and I found, on the contrary, that infarction of the posterior basal portion of the left ventricle is practically as common as infarction of the apex and anterior portion of the left ventricle. Likewise, the anterior descending branch was found to be occluded only slightly more frequently than was the right coronary artery in this series of cases.

In an authoritative review of all the literature on T wave negativity in "Physiologic Reviews" a few years ago the conclusion was reached that only negativity of the T wave in lead I or leads I and II was significant. Clinical observations convinced me that that was not true. I had seen clinical examples of negativity of the T waves in the combined leads II and III in patients who were dying of lesions producing strain predominantly on the right side of the heart. This led to the hypothesis that strain predominantly of the left ventricle, when it produced negativity of the T wave, resulted in inversion of the T waves in lead I or in the combined leads I and II. And further, that strain predominantly of the right ventricle could produce inversion of the T waves in leads II and III. Whitten and I were able to substantiate this hypothesis by combined clinical, electrocardiographic, and pathologic observations.

In the course of this investigation we encountered a discordant occurrence of negative T waves in the combined leads II and III in cases of hypertension. In searching the hearts which gave these manifestations for an explanation of this discrepancy, we found that in all but one or two of the hearts there was evidence of infarction in the posterior basal portion of the left ventricle. This led directly to the discovery of the electrocardiographic changes that permit prediction of the situation of infarctions involving the apical and anterior portion of the left ventricle on the one hand, and of infarction of its posterior basal portion on the other. When infarction occurs in the anterior portion of the left ventricle and apex, in the region usually supplied by the left coronary artery, the earliest electrocardiographic evidence of the fact is a change of level and contour of the S-T or R-T segment in leads I and II, and depression of the S-T interval in lead III. The R-T segment in leads I and II, but especially in lead I, is elevated above the iso-electric line. The segment is likely to be convex, dome-shaped, or sloping downward toward the T wave. Diphasic T waves, or T waves of a monophasic type, are the rule in the earliest stages. It is important to note that leads I and III act conversely, so that elevation of the R-T interval in lead I is opposed by depression of the S-T wave in lead III. The changes in lead II are usually seen to be similar to those in lead I in cases of infarction in the anterior portion of the left ventricle. Two or three weeks after acute coronary occlusion the monophasic or diphasic type of T wave is replaced by frank inversion. The T waves are likely to be deep, abrupt, or sharply peaked. Of particular significance in this later stage is the rounded contour of the R-T interval in lead I or leads I and II, preceding inversion of the T wave. At this stage, the R-T interval is approaching or has reached the iso-electric level.

With infarction in the posterior portion of the left ventricle, alone or combined with apical infarction, precisely the opposite set of conditions is seen. In this case, in the early stages, the R-T segment is elevated in leads II and III and depressed in lead I. The same convex, dome-shaped, or sloping R-T segment preceding the T wave is apparent in leads II and III. In the later stages, the R-T segment in leads II and III tends to return to and eventually reaches the iso-electric level, and the depressed S-T interval in lead I disappears. In this stage, inversion of the T wave in lead I is upright, and becomes exaggerated and more sharply peaked. It must be emphasized that if the patient survives for a period varying from six months to two years, evidence of inversion of the T wave tends completely to disappear and the electrocardiogram returns to normal.

This observation completely refuted the opinion accepted at the time it was made, that only occlusion of the branches of the left coronary artery produced significant or characteristic changes in the T wave.

In the same review of the literature on changes in the T wave cited in the foregoing, Katz concluded, largely on the basis of Smith's experiments, that only ligation of the left coronary artery in the dog produced characteristic changes in the T wave. I could not accept that, for we had shown that it was not true of the human heart. Accordingly,

Mann and I made experimental investigations, and found that ligation of branches of the right coronary artery produced electrocardiographic changes which were definite in type and characteristically different from those produced by ligation of branches of the left coronary artery in the dog.

THE PHYSIOLOGY OF THE BILIARY TRACT*

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Although physiologically the biliary tract appears to be of such little significance that many of the standard textbooks on physiology do not even mention it, clinically it is very significant because this structure is often the seat of disease conditions, many of which are helped or cured by surgical treatment. It is my purpose to review briefly the known physiology of the biliary tract. References can be made only to recent work, or reviews on the subject.

Anatomically the biliary tract consists of canaliculi, ducts, gallbladder, and possibly a sphincter at the entrance of the common bile duct into the duodenum. The comparative anatomy of the biliary tract is very interesting. All sorts of variations of its different components can be found in the different species of animals. Although in most species a more or less well developed gallbladder is present there is a considerable number which do not possess a gallbladder. It is not known why a well developed gallbladder should be present in one species of animal and absent in a closely related species. The relationship of the various ducts composing the biliary tract differs in almost every species of animal. The site at which the bile duct passes through the duodenal wall also varies greatly, being near the pylorus in some species and distant from the pylorus in other species. The relation of the bile and pancreatic ducts also differs widely. The physiologic significance of these great variations, if there is any, is unknown.[10,14]

CANALICULI

The canaliculi are the beginning of the biliary tract. They lie between the cords of hepatic cells making up the trabeculae. They drain outward from the central vein of a hepatic lobule to the ducts in the portal spaces. It should be noted that the patency of the lumen is greatly dependent on the hepatic cells and that obstruction can occur when the hepatic cells become swollen. The intrahepatic ducts of the liver are characteristic but so far as is known, do not have any other function than to form a passage for the outflow of bile, although under special conditions there are marked changes in the demonstrable fat content of the mucosal cells lining the ducts.

GALLBLADDER

The gallbladder is by far the most interesting part of the biliary tract. It has often been said that the gallbladder is a functionless structure. This statement was based on the following facts: (1) a clearly defined function has never been proved; (2) many species of animals never possess a gallbladder, and (3) removal of the gallbladder is not followed by any demonstrable harmful effects. However, there are five known facts which indicate that the gallbladder is of physiologic significance: (1) the extrahepatic biliary tract dilates after removal of the gallbladder; (2) the gallbladder concentrates the bile which enters it; (3) the gallbladder can empty; (4) it empties by contraction of its intrinsic musculature, and (5) a substance, cholecystokinin, normally found in the duodenum, will cause the gallbladder to contract and empty. Most of these facts have been noted recently.

Numerous investigations have demonstrated that removal of the gallbladder is usually followed by dilatation of the extrahepatic ducts. One of the earlier publications on this subject was made by Judd and me. Since publication of this article I have removed the gallbladder from animals of several species and found that dilatation of the extrahepatic ducts usually occurs although occasionally no change in the size of the ducts is found. This fact, that the removal of the gallbladder produces a demonstrable effect, proves that the viscus is of physiologic significance.

It has been known for many years that the bile in the gallbladder contained a higher concentration of biliary constituents than the bile as secreted from the liver.[7] However, it was not until Rous and McMaster devised a method for obtaining specimens of bile from the gallbladder and hepatic duct separately, that a quantitative estimation of the constituents of the bile from the two sources could be made. The biliary duct in the dog is arranged so that it is possible to obtain bile secreted by some of the lobes of the liver direct and to permit bile secreted by the other lobes of the liver to enter the gallbladder. When Rous and McMaster estimated the pigment of the bile from these two sources, they found that the bile which entered the gallbladder had been concentrated seven to eight times.

Bollman and I found another method of demonstrating this concentrative action of the gallbladder. When the common bile duct of a dog with a normal biliary tract is occluded the presence of a demonstrable amount of bilirubin does not occur before thirty to forty hours after the obstruction of the biliary outflow. However, if the gallbladder is removed at the same time the duct is obstructed demonstrable bilirubinemia occurs within six hours

* Read at the Indiana University Seminar, Indianapolis, Indiana, March 25, 1932.

after ligation of the duct. These findings indicate that although the capacity of the gallbladder is so limited that it can only hold the bile that is secreted over a period of about two hours, by removing the water from the bile which enters it the gallbladder is able to contain all the bile secreted for more than twenty-four hours.

It has often been said that the gallbladder never empties. This statement was based on the fact that the surgeon at operation and the pathologist at necropsy always found that the gallbladder contained bile. A few years ago, when I wrote a review of what was then known concerning the functions of the gallbladder, I was forced to admit that it had never been proved that the gallbladder did not empty. However, Boyden[1] proved conclusively what is now well known, that the gallbladder does empty. He was interested in a study of the pancreatic ducts in cats and had fed the animals egg yolk and cream a few hours before killing them. He noted that the gallbladder of the animals that had received the fat meal was empty Numerous investigations, carried out on many species of animals, have amply confirmed Boyden's original observation.

After it had been definitely proved that the gallbladder did empty, the question arose as to how it emptied. Numerous conjectures arose with regard to this part of the biliary mechanism. The most important of these conjectures are the following: (1) the changes in abdominal pressure in association with respiration might be responsible; (2) the elastic tissue in the gallbladder responded to changes in pressure in the viscus similar to the walls of a rubber balloon, and (3) since the common bile duct in many species of animals passed obliquely through the wall of the duodenum, peristalsis in the latter might empty the viscus by suction in a milking manner. However, it was found that none of these conjectures was tenable. In the intact abdomen, the changes in pressure associated with respiration probably act on the site of discharge of bile the same as on the gallbladder. Furthermore, Higgins and I found that the gallbladder of the fish, in which respiratory abdominal changes in pressure are absent, emptied following the ingestion of the fat meal the same as the gallbladder of the cat. We also obtained emptying of the gallbladder in several species of animals in which the abdominal cavity was widely open. Recoil of the elastic tissue of the wall of the gallbladder would not produce the complete emptying of the viscus noted in some species of animals, as the cat and spermophile, after ingestion of fat. In some species of animals in which the gallbladder was found to empty more or less completely after the fat meal, the common bile duct passes through the duodenal wall almost at right angles, so that a milking action was hardly possible. Furthermore, the gallbladder cannot be emptied to any great extent by suction with a syringe attached to the common bile duct.

By injecting an opaque medium in the gallbladder and then taking roentgenograms at various periods after administering a fat meal, Whitaker and Boyden, Hamrick and Whitaker demonstrated that the gallbladder appears to empty by contraction of its own intrinsic musculature. That this was the mechanism whereby the gallbladder empties was completely proved by Higgins by observations on fish. It was found that by suitably preparing a fish the gallbladder could be observed directly. It was always distended and quiescent in the fasting animal. However, shortly after a few cubic centimeters of egg yolk and cream had been passed into the duodenum, peristaltic waves could be seen starting in the gallbladder either at the neck or fundus, or at the juncture of the cystic and common bile ducts, passing over the viscus, forcing bile from the gallbladder into the duodenum. In a less satisfactory manner the gallbladder of the guinea pig, cat and spermophile have been seen to empty.

There is no question then, that the gallbladder in many species of animals probably including man,[2] can and does empty by contraction of the muscles in its walls. Whether subsidiary factors are of any significance in the mechanism of emptying the gallbladder have as yet to be proved. The rate and degree of emptying in various species of animals differ. In some animals the contraction waves are readily visible as peristalsis. In other species only a gradual diminution in size without visible contraction waves is discernible. The gallbladder of some species empties completely, and in others a completely empty gallbladder is never seen.

The stimulus causing the contraction of the gallbladder was the next logical step to investigate. Various foods were used, but Boyden's original meal of egg yolk and cream proved to be the most efficacious. However, Ivy and his co-workers were able to obtain a substance which they named cholecystokinin, from the duodenal mucosa, which, when injected into an animal, caused the gallbladder to contract and empty. It would appear that cholecystokinin is a substance of physiologic import, although it has not as yet been isolated in pure form. Whether it is the only stimulus for contraction of the gallbladder has not been proved.

How the gallbladder fills with bile has been as puzzling as how it empties. It is obvious that in many species of animals the gallbladder could not fill by gravity; some mechanism exerting pressure on the common bile duct appeared essential. Thus started the controversy whether a special sphincter is present at the duodenal end of the common bile duct, or whether tonus of the duodenal wall is the only factor causing resistance to the outflow of bile. Anatomically, a special sphincter around the common bile duct has often been described although its presence has been denied. The question is still an open one and I shall not consider it here as Giordano and I, as well as Puestow, have recently presented a review on the subject. There does not appear to be any question that a physiologic mech-

anism is present in the duodenal wall at the site of passage of the common bile duct which regulates the discharge of bile. The recent work of Puestow, who developed a method for making direct observation of the discharge of bile into the duodenum, adds more conclusive data to the large number of preceding observations which would appear to indicate that this special physiologic mechanism is real. Other recent work would indicate that it is a true sphincter.[16]

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ROENTGENOLOGIC DIAGNOSIS OF EARLY PULMONARY TUBERCULOSIS*

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Roentgenoscopy is inadequate either to disclose or exclude the presence of early tuberculosis, and roentgenography, which preferably should be stereoscopic and rapid, is essential for decisive results.

Only rarely in cases in which there are clinical manifestations of the disease are roentgenologic signs absent. The converse occurs far more often, and cases without number can be cited in which the affection was disclosed by the roentgen ray when clinical symptoms were vague, trivial or absent.

Practically all cases of incipient tuberculosis among adults may be classified in two groups. In the first, and by far the larger group, the earliest characteristic manifestation is a faint conical or fan-shaped shadow in an upper lobe, more often the right. It lies obliquely below the clavicle in the first or second interspace, with its apex toward the hilum, and its base, which is at the periphery of the lung, is often directed toward the axilla. The shadow is made up of a confused network of delicate lines enveloped in a filmy veil, and its appearance has been aptly compared to that of a caterpillar's web on an outer branch of a tree. In the second group the lesions are likewise situated in the outer parenchyma below the clavicle, but are more or less spherical, sometimes single, more often multiple. In size they vary from a diameter of one or two millimeters to several centimeters. When multiple they may be discrete or closely aggregated and are likely to be diverse in size. The individual shadows are faint, although denser at the center than at the periphery, the latter being especially hazy and indistinct.

Common to both groups is an accentuation of the bronchovascular trunk leading from the affected region to the hilum. Occasionally the ribs on the affected side descend more steeply with resulting narrowing of the intercostal spaces, but this more often accompanies advanced disease.

Four prime characteristics of early tuberculosis should be kept in mind in the differential diagnosis: (1) its situation below the clavicle and in the outer parenchyma of an upper lobe; (2) the roughly conical or spherical form of the lesions; (3) the softness and lack of marginal definition of the shadows, and (4) the accentuation of the tributary bronchovascular stem. Few of its simulants have all of these characteristics. Among simulants to be considered are: bronchiectasis, the lateral border of an azygos lobe, malignant metastasis, shadows from clothing or other extraneous causes, emphasis of bronchovascular markings without correspond-

* Synopsis of paper presented before the Indiana University Seminar, Indianapolis, March 25, 1932.

ing parenchymal shadows, localized simple pneumonitis, and small healed or arrested tuberculous lesions.

Especially to be deprecated is the diagnosis of "peribronchial tuberculosis" on the sole basis of an intensified shadow of the hilum with emphasis of the principal vascular markings. The roentgenologist should never venture a diagnosis of tuberculosis unless shadows are demonstrable in the outer parenchyma. Occasionally even these are deceptive, especially when they are produced by a restricted simple pneumonitis resulting from a cold or other ordinary infection and situated in an upper lobe. It may be exhibited as a hazy fan-shaped shadow, probably representing congestion chiefly, or as a small mottled patch depicting narrowly localized bronchopneumonia. In either case the situation and appearance of the lesion, together with the exaggeration of the tributary bronchovascular stem, are identical with those of one or the other type of early tuberculosis, and the roentgenologist will be inclined consistently to make the latter diagnosis, at least provisionally. In such cases the clinician can avert error by withholding judgment, observing the course of the infection, examining sputum frequently and sending the patient for re-examination. Fortunately acute simple infections of the lung commonly attack lower lobes, and invasion limited to an upper lobe is rare, but it should always be considered when colds, pneumonia and influenza are prevalent.

Small healed tuberculous foci, which are so often found in adults, should not be mistaken for active lesions. The shadows are relatively dense and sharply delimited from the normal tissue, and the main vascular trunk is not accentuated. Marginal haziness is the indispensable roentgenologic mark of activity. It undoubtedly represents the reactive inflammation and congestion about the lesion and is a reliable criterion. However, patients with identical evidences of activity may not be identical clinical problems. Further, distinction between haziness and sharpness of margin depends to some extent on the personal equation of the examiner, and technical factors, such as blurring by respiratory or other movement by the patient, may alter marginal definition. For these reasons, co-operation and mutual understanding between roentgenologist and clinician should be thorough.

Exceptionally, adults are attacked by primary tuberculosis like that of children and with similar roentgenologic phenomena. A lower lobe or the circumhilar region may be affected, and although the manifestations are obvious, the examiner cannot logically attribute them to tuberculosis. In most cases the appearance resembles that of bronchopneumonia and is likely to be so interpreted. As the symptoms and physical signs are also atypical, diagnosis in these cases usually requires combined and prolonged roentgenologic and clinical study.

Primary tuberculosis of children differs in many respects from the secondary form common in adults. When puberty is reached, almost all children have been infected by the bacillus of tuberculosis, and it is generally accepted that the initial pulmonary lesion is in the parenchyma rather than the lymph nodes, although the latter react most conspicuously. In a large majority of cases the initial lesion is arrested, but it may extend to produce clinically important primary tuberculosis. Occasionally, also, after subsidence of the initial infection, children acquire secondary tuberculosis like that of adults.

Since primary infection among children is the rule, its confirmation by the roentgen ray in a given instance, if possible, would scarcely be important. Often mediastinal lymphadenopathy is pronounced; the median shadow is greatly widened, its borders may be polycyclic, and the larger vascular markings may seem to be accentuated. The Ghon focus, which is small, usually single, and situated in the parenchyma of any lobe, may be visible as a somewhat rounded or irregular shaped shadow. However, the mediastinal shadow is commonly wide in children, and it may be greatly enlarged for many weeks after measles, whooping cough or other infectious diseases. Identification of a particular parenchymal shadow as that of a Ghon focus is necessarily uncertain. Hence, although the roentgenologic picture may give assistance, the problem of primary infection is chiefly clinical.

When the infection has produced disease of the parenchyma of grave importance the manifestations are more striking, but still difficult to interpret. The focal lesion may be situated in any of the lobes but it has a predilection for the lower portion of the lobe invaded or the circumhilar region. Its shadow may be fan-shaped or irregular, and at first is homogenous with the appearance of ground glass, later becoming mottled. The median shadow is widened, and the radicular markings are accentuated. But the entire picture cannot be distinguished with certainty from that of bronchopneumonia or lobar pneumonia, and final diagnosis must be left to the clinician.

To sum up, it may be said confidently that without routine employment of the roentgen ray, many, if not most, of the truly early cases of pulmonary tuberculosis will escape recognition. As a single rapid method for definite revelation of the lesion, the determination of its probable nature and even the estimation of its activity, I do not believe that the roentgenologic examination is surpassed by any other. But the method also has its limitations and is easily susceptible of abuse by inexperienced and incautious observers, who are slow to realize that the normal thorax has a wide range of variations and who are prone to find evidence of disease when none exists. It is always essential, therefore, that the roentgenologic data be correlated with the clinical, for the two methods are interdependent and indispensable to each other.

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JULY, 1933

EDITORIALS

THE MISMANAGEMENT OF JUVENILE SQUINT

The mismanagement in this type of case too often begins soon after its onset, because of illy-advised parents. It would seem, with all the wholesome advice that has been given in the past, together with the propaganda set forth in the medical press, that at least medical men would be alive to the importance of early treatment. However, this is not always the case; we constantly see cases in which the squint is a matter of perhaps several years duration and in which the family physician is allegedly charged with having advised that "the child will outgrow it."

Nor is this thing of mismanagement chargeable solely to the general practitioner; too many of our oculists are at least lax in their activities toward the relief of this distressing condition. We have known oculists to suggest that the child was too young to do anything about it; on numerous occasions we have found such little patients wearing grossly improper corrections. If we are to derive much satisfaction from our results in early squint, in children under the age of two years, we must refract as we have never refracted before; we must, indeed, be most meticulous in our work, for nowhere else in the field of refraction must we exercise such care as in the handling of these cases.

Again, the oculist who is not willing to spend lots of time and does not possess infinite patience in the handling of small children will do well to refer these cases elsewhere; one cannot expect good results otherwise. It should be an inviolable rule never to make a definite appointment for a refraction in such a patient until the most friendly relations have been established with the patient, and until we are certain that he will be perfectly amenable to suggestions regarding where to look, etc. We believe this to be the greatest factor toward success in handling cases of this kind.

No matter how young the patient, the parents should be advised to seek competent advice as soon as a squint is noted. As a matter of course this means referring them to the oculist—*not to the optometrist or optician!* We insert the latter remark because of the amazing fact that a considerable number of physicians refer such patients to these folks. All evidence to the contrary, a proper refraction cannot be made without the use of atropine.

We remarked that occasionally some of our oculists are chargeable with poor results; not seldom have we had occasion to recheck cases, only to find that improper and incomplete corrections have been given. We could cite innumerable instances in support of this contention, but one or two will suffice. Comes a little tyke who had been wearing a correction, without result, for a matter of more than a year. She had been given a plus 2.00 sphere, with a moderate degree of cylinder correction. Out retinoscopic finding resulted in a correction of plus 6.00, with considerable cylinder; within a very few months the squinting eye was very much improved and soon was unnoticeable, so long as the glasses were in place. Again, a little group of patients from a neighboring community were found to be wearing myopic lenses, while a retinoscopy showed marked hyperopia in almost every instance. One of this group had been given a minus 1.50 spherical correction; we changed this to a plus 5.00 spherical, with a complete correction of the squint in a short time.

Our experience is that marked improvement, if not complete correction of the deformity, can be had if the patient is seen early and is properly fitted. Refraction, even if properly done, does not always produce such good results; we are often impelled to use other measures in conjunction with this very valuable agent; but it is not our purpose to enter into a discussion of the treatment of squint. We are of the opinion that surgical procedures are entirely out of place in the great majority of cases of juvenile squint, though we do recognize this to be a moot question. Our immediate concern is that these patients be sent to competent oculists as soon as recognized, in order that every opportunity for relief may be afforded.

THE CLASSIFICATION OF MATERNAL DEATHS

Maternal deaths have usually been classified roughly as due—25 per cent to infections, 25 to toxaemias, 25 to hemorrhages and the other 25 per cent to include all the other causes. Those interested in obstetrical mortality statistics complain that neither do the total deaths decrease nor the percentages change. One cannot expect much im-

provement if the classification of maternal deaths is not regarded in a different light considering the possibilities of modern obstetrical art. Classifying a maternal death as above is like saying "God's will be done," when a mother dies as a result of labor.

In signing death certificates the old classification will, of course, be adhered to but in the staff meetings and in medical meetings where maternal deaths are discussed a different approach will bring a better analysis in finding the "primary avoidable factor."

In an investigation by Janet Campbell for the English Ministry of Health we find an approach with the above "factor" in view. In investigating 1,596 maternal deaths she found one or more of the four classifications listed below applicable in about one-half the cases. The classification with percentages are:

1. Omission or inadequacy of ante-natal examinations (34%).
2. Errors of judgment in the management of the case (36%).
3. Lack of reasonable facilities (12%).
4. Negligence of the patient or her friends (18%).

I believe that the classification responsible for the greatest number of deaths would be errors in judgment on the part of the attending obstetrician. Undoubtedly at times the management given was the best sincere judgment of the attendant but nevertheless it might not be the best in the light of modern obstetrical judgment. The study of the management of a mother who has died in giving birth to a child should be in the same way that a pathologist investigates the body of a patient dead of internal disease. The postmortem may reveal many things which, in another similar case, might improve the clinical management.

There will always be a goodly percentage of deaths for which the management of the individual case cannot be held responsible for the result such as severe primary hemorrhage of a central placenta praevia; the occasional case of autogenous puerperal infection; the occasional fulminating type of eclampsia and the occasional other uncontrollable accidental hemorrhages.

There will, no doubt, always be the group where the physician's advice in competition with that of the patient, the family or the neighbors will lose out, and the woman will be the victim of stubbornness or superstition.

Some mothers must continue to suffer from lack of proper surroundings for the satisfactory handling of emergencies. These deaths must, however, be classed as preventable. But, if a mother has passed her eighth month of gestation and has developed all the warning signs and symptoms of an impending eclampsia and is allowed to stay undelivered until convulsions develop and she dies, this should not be considered a death from toxaemia but a death due to an error in judgment or neglect on the part of her attending physician. The comparable situation is an individual with all the classical symptoms and signs of acute appendicitis who is allowed to stay unoperated upon until rupture and peritonitis develop with his death.

If in the presence of a prolapsed cord and a partly dilated cervix a rapid delivery is attempted with the death of the mother from hemorrhage and also a stillborn child; if with a floating head and an incompletely dilated cervix a forceps delivery is attempted with a tear into the broad ligament with hemorrage and death; if a rapid delivery is attempted with a Braxton-Hicks version and a deep cervical tear causes hemorrhage and death; if a large dose of pituitrin is given to a woman in labor who has had a previous delivery by caesarean section and she has a uterine rupture and death—should these be classed as deaths from hemorrhage or deaths from errors in judgment on the part of her attending physician? If a mother, after her tenth baby, bleeds profusely and the physician does not have at hand pituitrin, ergot or a uterine pack and the woman dies from hemorrhage, is this a death from hemorrhage or "lack of reasonable facilities" or "error in judgment or foresight on the part of her physician?"

If a simple classical caesarean section is done after a prolonged labor and in the presence of a known utero-vaginal infection and the patient dies of peritonitis, or if after doing an autopsy on a person dead of sepsis or after opening an abscess the attendant delivers a woman without carefully scrubbing his hands and the woman dies of sepsis, this should not be classed as a death from sepsis but an error in judgment and carelessness.

If a woman with a known deformed pelvis is allowed to remain in labor for days without adequate food and water and dies from exhaustion and shock when an early caesarean section could have saved her, the cause of death should be error of judgment or neglect.

Likewise, if a hospital puts an obstetrical case on general floor care with a case of a draining pus wound close by and the mother dies of sepsis, this is not a death from sepsis but one due to lack of judgment or hospital carelessness.

The opinion exists that anyone can take care of an obstetrical case and only as a last resort will the patient be referred to a hospital or to some one recognized as especially adept in obstetrical procedures. Frequently prolonged unsuccessful attempts are made at forceps delivery followed by unsuccessful attempts at version-extraction and a patient, completely exhausted, is sent to the hospital where a consultant gets the unjust credit of signing the death certificate.

Surely a mother in pathological labor and her unborn child deserve the equal of the attention that is given a patient with gall-stones, acute appendicitis or a ruptured gastric ulcer. And the attending physician does not usually open the abdomen in the home and make unsuccessful at-

tempts at surgical procedures, then send the mussed-up abdomen to an efficient surgeon. Does not a case of central placenta praevia, an impending eclampsia, or an obviously badly contracted pelvis deserve hospital care from the start for satisfactory results?

There can be little doubt that many women in labor, even in the shadow of good hospitals and kinder care, even within the hospitals themselves, go through greater tortures than the Spanish Inquisition in its heydey ever meted out and this because of indifference, carelessness or poor judgment on the part of their attending accoucheurs.

AGAIN, THE HOSPITAL

While the expense of the Committee on the Costs of Medical Care was magnanimously borne by philanthropic agencies, it now seems that the medical profession owes those agencies a debt of gratitude which at first was not apparent. In the least of our bureaucratic tendencies was that which was rapidly assuming the management of our health problems from our begetting to our ending. While the medical profession was aware of these social trends there was no concerted effort to stem the tide.

Then came the awakening. It was sudden and complete. Under the leadership of the officials of the American Medical Association, there has been and is being developed a sense of proportion in the inter-relationship existing between the patient and his physician. From this study there will come also a better understanding of the relationship of the physician to the hospital and of the hospital to the physician, for here an actual symbiosis exists. They are useless each without the other. The parties in such a dependency should not compete one with the other. A hospital which is known as a charity institution, in that it is giving its services to the poor, may well employ resident physicians the better to render medical care to the indigent; in fact, any hospital should render the best service possible to its guests. But when a hospital in rendering that service employs resident roentgenologists, laboratory directors, and the like, for the purpose of making a profit, that hospital is competing with physicians in private practice. Outpatient service is plainly competitive. To clarify: Let us imagine a hospital operating a complete surgical service or a complete obstetrical service; few physicians would sanction such a plan; yet the maintaining of any one branch of medical practice for a profit to a hospital differs in degree and not in kind from the policy of maintaining several branches. It is sufficient to mention that the principle is wrong and should be condemned.

SEEING INDIANA

We are all familiar with the slogan, "See America First!" This has been dinned into our ears for a considerable time and a good suggestion it is; however, before seeing America, why not see our own State of Indiana? Countless numbers of native Hoosiers have never seen their own state; a great proportion have no idea of the wondrous beauties to be found in the southern part of Indiana. We admit a personal guilt to this indictment, prior to about a year ago, when we took the family chariot and the various members of our menage and rode for a thousand miles down among the "Cumberland Foothills."

Within a few weeks you will be wending your various ways toward French Lick, there to attend our annual meeting; this trip in itself is one of much beauty and pleasure, now that hard-surfaced roads are to be found throughout that section. After seeing Orange County, one is but on the border of Wonderland. We have not by any means covered southern Indiana, but we have traversed enough of that territory to justify the advice given to "See Indiana First."

Those living in the northern part of the state would do well to take a routing through Brown County; and we especially recommend the road from Nashville to Bloomington, thence south and west to French Lick. Then, if you have even a day or two, you will be well repaid if you will go on down to the Ohio river. The road to Evansville is a thing of beauty, winding in and about the hills as it does. A little swing over into Posey County, and a visit in New Harmony, will give one an afternoon of much pleasure. Thence east, either via the upper or lower route, pausing to visit the park dedicated to the memory of Nancy Hanks Lincoln, eastward through St. Meinrad, the site of the beautiful Benedictine Abbey, on and on until one nears Leavenworth, where one involuntarily stops the car, there to view what we believe to be the most beautiful spot on the Ohio.

A bit farther to the east one comes to Wyandotte, near the famous cave of that name. A very comfortable hotel is located at the entrance to the cave and the Reilley brothers will take care of your every want. Competent and educated guides make one's trip through the cave well worth while and the constant temperature of fifty-two degrees conduces to personal comfort during the various hikes available in Wyandotte cave. A bit to the north is Marengo cave, which we have not as yet explored, but which undoubtedly is worth a visit.

Thence on into Corydon, the site of Indiana's first capitol. This building is in an excellent state of preservation and is under the control of the Department of Conservation. An elderly native serves as custodian and guide and entertainingly tells the visitors an interesting tale of the early days in that part of Indiana.

Turning northward on leaving Corydon, one travels to Salem, in Washington County. It is one of the old towns of the State and it affords opportunity for an hour or more of much pleasure to the tourist; then on through Scottsburg and to

Clifty Falls Park, near Madison. Here the Department of Conservation has a modern hotel, situated on the edge of the bluff and affording a view of the Ohio river and the hills of Kentucky and Indiana for many miles in either direction. One will do well to explore Clifty Canon, even though the climb up and down may cause some shortness of breath. By all means run over to Hanover College, just a few miles away; this college was founded in 1827 and still is going strong. Hanover, too, affords many beautiful river views.

Of course, one must see Madison, one of the old river towns of Indiana. Here the Department of Conservation offers a treat to those who visit Madison; the Lanier Home is visited annually by thousands, all of whom are of one accord in pronouncing this one of the most interesting of the many things worth seeing in southern Indiana. At the top of the hill is located the Madison State Hospital for the Insane, known as "Cragmont," a visit to which will be most interesting to physicians. The river view from this point is most entrancing.

Turning homeward from Madison, one has several routes from which to choose, each of which affords pleasing countrysides and glimpses of many of our cities and towns. Any one of the routes will prove comfortable driving. Add a day or two to the time allotted for your annual meeting vacation and see Indiana; we are sure you will enjoy the outing, and will return to your homes with a more definitely fixed notion that Indiana is indeed "no mean State."

MEDICAL BOOKS IN GENERAL AND MEDICAL TEXTBOOKS IN PARTICULAR

Modern medicine has become so extraordinarily complicated that it is impossible for any one person to be any sort of an authority over more than a very small section of it. Even then to do so he must spend years and years of the hardest kind of study. How, then, can we expect the general practitioner who theoretically should know a great deal about every specialty, to keep himself even reasonably well informed? Let us suppose that the general practitioner should wish to keep up on various phases of medicine. He would have to spend two or three hundred dollars for textbooks every few years. He would have to take a dozen periodicals. By the time that he would read these books and periodicals he would have no time for anything else. Likewise the medical student is in a similar dilemma. It is presumed that he knows very little about the various subjects that he is studying when he begins the course. He usually is given a textbook two inches thick which he is expected to master more or less completely in the space of a semester or so. In other courses he has other large books. The trouble with these books is that they have all been written by specialists in that particular line and rarely or never written by persons with an understanding of pedagogy or with an appreciation of the needs of the practitioner or the student who is preparing to become a practitioner. As one reads these books he is frequently inclined to the opinion that the book is written principally for the impression that it will make upon the reader as to the scholastic standing of the author. In many instances the authors are so afraid of being called didactic that they do not succeed in expressing themselves in a positive manner on any subject. We appreciate the need of highly scientific books and articles and in such publications the author by all means should bring out the various controversies and opinions pro and con. In textbooks, however, for elementary education and for the use of the practitioner who wishes to bring himself up reasonably well in a line in which he is not specializing, there is entirely too much of this high-brow stuff. We recall, for example, the story of the professor who taught his junior medical students in the following highly instructive manner: "In this disease the patient may have a leukocytosis or in many cases a leukopenia. In some cases, however, there is no change in the white cell count." What practical conclusion about the particular disease (which incidentally nearly always produces a definite leukocytosis) could the student draw from such a statement? We understand that the statement is true, and that in a postgraduate clinical discussion such handling of the subject would be excellent, but we refer here to undergraduate classes.

We would not have the reader of this editorial believe that we think that a medical student is in danger of learning too much. It is merely that we are afraid that in attempting to learn a potpourri of everything he may learn almost nothing that he actually can use. We recall that in the study of anatomy we learned an enormous mass of fine detail without any particular emphasis on any of it, and as a result we feel as if we had forgotten our anatomy en masse. Possibly if we had been taught our anatomy in such a way as to have had the important points brought out, we would have forgotten much less of it that is right to the point. We recall that we learned, after considerable effort, the course distribution and function of the Vidian nerve. So far as we can now recall we have never heard the Vidian nerve referred to since then in any practical way. Are there not means by which the really important subject matter of the course might be put in concise and readily understandable language, so that those who are not specialists in the subject can get it with a minimum of effort? What we need is more books which go to the heart of the subject leaving out most of the confusing controversy over fine points, easily read and no larger than they should be to present the subject in the elementary manner which the student and which the practitioner needs when he is reading outside his specialty. In that way the books would be much more economical of time and money and

probably serve the purpose better. By this we do not mean that they should be carelessly written or that they should be written in a condescending manner. There is no reason why we should regard a man who asks a specialist to speak in common language as being ignorant or poorly informed. It is simply that there is too much to learn for people to be expected to get all of it. A thousand thanks to the publisher who will come out with a series of texts which are not so heavy that they would sink a battleship or so dry as to put one to sleep in the first chapter. Incidentally, it is probably harder to write books of this sort than it is to set down a jungle of facts through which only an experienced guide might expect to find his way.

EDITORIAL NOTES

DEAR DOCTOR:

THE JOURNAL and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital.

We invite and urge you to use this Service.

It is absolutely *free* to you.

The Cooperative Bureau is equipped with catalogues and price lists of manufacturers, and can supply you information by return mail.

Perhaps you want a certain kind of instrument which is not advertised in THE JOURNAL, and do not know where to secure it; or do not know where to obtain some automobile supplies you need. This Service Bureau will give you the information.

Whenever possible, the goods will be advertised in our pages; but if they are not, we urge you to ask THE JOURNAL about them, or write direct to the Cooperative Medical Advertising Bureau, 535 N. Dearborn St., Chicago, Illinois.

We want THE JOURNAL to serve *you*.

Now is the time to immunize school children and pre-school children against the increase in diphtheria that is sure to come next fall. Physicians and county medical societies are requested to emphasize diphtheria immunization at this time. Get the children really ready for school next fall.

WARNING! We have received notice to the effect that a former representative of Cleveland Nurses Apparel is thought to be operating in Indiana, selling doctors' gowns, and collecting money. The Cleveland Nurses Apparel Company advises us that they have no representative outside the city of Cleveland, and any one representing himself as their agent is an impostor and a fraud.

WE again call your attention to our advertisers and urge that you mention THE JOURNAL when writing them; this helps a lot. Talking with exhibitors at the Milwaukee meeting of the A. M. A. recently, we heard many of them express the wish that doctors might mention their State Journal when in communication with them; they like to know that their advertising is read.

THE degree of Doctor of Science was conferred on Dr. William Niles Wishard, of Indianapolis, at the one hundredth commencement of Hanover College, June sixth. Luther Wishard, a brother of Doctor Wishard, was instrumental in founding the Y. M. C. A. at Hanover, and it was through his efforts that the first college Y. M. C. A. building in the world was erected on that campus, fifty years ago.

MANY of the advertisers in your journal are exhibitors at the World's Fair in Chicago. When you visit the fair, be sure to look them up, and tell the attendants why you are looking at their exhibits. The pharmaceutical and chemical exhibits in the Hall of Science are well worth the time of any visiting physician. Along with these are the exhibits of the American Medical Association and the American College of Surgeons.

MANY of the health bulletins and similar magazines that come to our editorial offices have commented, recently, upon the decrease in the consumption of milk. The fact is noted with alarm because growing children are not receiving the amounts of milk that they should have to insure proper growth and strong, healthy bodies. This is one of the worst effects of the financial depression, the consequences of which will be apparent in future years.

MANY vacationists have heeded the warning about unsafe water; your patients should be warned to exercise the same care in using milk. Undulant fever may be contracted through the drinking of raw milk or cream from animals infected with contagious abortion, and all vacationists should make sure that they are using pasteurized milk or certified milk. Campers who purchase milk from any farm home along their route are inviting disaster.

WITHOUT doubt you have noted that the June and July numbers of THE JOURNAL are "thinner" than usual; this is customary with State Journals, what with the seasonal reductions in advertising and the vacation periods for most medical folks. Then, too, we find it advisable to reduce THE JOURNAL during the summer months because of the large number of pages in the September number, this being the annual session issue, when we step up the number of pages to a very high degree.

A RECENT advertisement of an optometrist calls attention to the fact that he will be away to do some postgraduate work "covering some new developments for the better care of the human eye, as perfected in the famous eye clinics . . . in Phila-

delphia." The advertisement further states that the "Dr." will be absent in the interest of his patients and, in keeping with the best traditions of the professional man, he sincerely wishes to render the very best service. Well, it pays to advertise!

IN *Colorado Medicine* for June appears the line, "Take this journal home to your wife." This is very good advice, for most wives of physicians enjoy their State Journal. Time was when the wives of medical men were not supposed to be interested in things medical; in fact, shop talk was taboo in these homes. Now, what with our woman's clubs, our auxiliaries, and similar organizations, our women folk are very much interested in many of our medical problems. Hence we are inclined to agree that the suggestion above mentioned is a timely one.

IN the consideration of plans for caring for indigent medical relief it is absolutely necessary that two things be borne in mind: that all purely mercenary considerations must necessarily be discarded, and that all purely personal advancement is taboo. We mention this because of the fact that both these evils have appeared in numerous places where the question has been considered. It is entirely unreasonable to expect our larger counties to pay regular fees for this work but it is reasonable to expect our profession to assume its proper share of the burden.

SUMMER, the play season, is now with us. Proof of this lies in the fact that Indiana saw the hottest June in her history, and that weather conditions seem to have sapped much of the pep from our folks. The very best and the most pleasant remedy for this lies in recreation, no matter what sort, just so it includes relaxation. For some it means golf, and lots of it. Sure enough, one can relax in this game, as in all others. For us, it means taking a rod in hand and using the various methods of attempting to lure the finny tribe. By all means rest a bit, even though it is but for an occasional afternoon.

BRYAN, in the *Journal of the Tennessee Medical Association*, June, 1933, cites some interesting data in connection with the treatment of tetanus by the intravenous use of 1 per cent phenol. He enumerates twenty-one cases treated in Vanderbilt Hospital, with eleven deaths, with no mortality in those cases treated with the phenol solution. Four of the cases were treated with phenol in conjunction with antitetanic serum and all recovered. His personal record is six cases who received the phenol treatment, and of whom all recovered. The article is exceptionally well written and should prove of much interest to the profession.

A NEW "directory" makes its appearance in this issue of THE JOURNAL. A few of Indiana's ethical prescription shops are carrying their announcements in this issue; others probably will be added later. We urge each and every physician, whenever possible, to patronize those firms whose announcements or advertisements appear in THE JOURNAL. Without their support your JOURNAL could not exist. Their continued support through a period when many have felt it necessary to abandon all advertising programs makes them doubly deserving of your patronage and we hope that whenever possible our members will show their appreciation of the loyalty displayed by our advertisers.

MALPRACTICE suits continue to multiply all over the country and our own State of Indiana furnishes a goodly supply. Our observation is that many of these pestiferous affairs are brought on by some slurring remark of a confrere. A recent case, in which the defendant doctor was assessed a sizeable judgment, brings the matter again to our mind. Within a very few hours after this case had been concluded two attorneys were heard to say that they were now ready to file similar suits; they were waiting to see how this case came out. We happen to know that the shoe is about to be put on the other foot—that the doctor who is charged with aiding and abetting this case will soon be called upon to defend himself in a similar suit. Old Man Retribution is ofttimes slow in catching up with one, but eventually, like the C. M. P., he gets his man.

OF all the pests with which editors of medical journals have to deal perhaps the worst are those who from other states send in unsolicited manuscripts for publication. Only recently did we have a so-called paper sent to us, this from a chap in an eastern city. There was little or nothing worth while about the paper; it was poorly written and personally typed on a machine that sorely needed the services of a good cleaner. Checking up on the author, we find that he is not a present member of his county society and has not been for some years past, which fact probably accounts for his sending his brain child to a journal some distance removed from his own bailiwick. Not seldom do we see such matter in some other state journals. It is not hard to recognize these offerings, for they are universally poorly written and bear little evidence of having been prepared from the personal experiences of the writer.

Two "clinic" patients dropped in, recently, each with an interesting story of their experiences. One had learned of the "free" service to be had in a clinic said to be conducted by one of our large

medical schools. This man wanted glasses, and felt that the charge of his local oculist was exorbitant. The sum total of his experiment in money saving was that he was required to "lay off" for two and one-half days, and was finally advised that his bill would be something like thirty dollars! He immediately returned to his home town and engaged the services of his local oculist. The second sought an examination in a second clinic, this latter organization apparently being in business for purely commercial purposes. The bill presented at the conclusion of the performance was some fifty-eight dollars. Many of the special examinations were, in our opinion, entirely unnecessary. Would not these experiments indicate that very often the clinic addict pays dearly for his experience?

ONE of the chiefest joys in the life of a medical editor lies in reading the letters that come in after every issue. The letters we enjoy most are those having to do with some editorial contribution written by another, particularly when the letter in question is of a most critical nature. The editor does not write all the editorials nor all the editorial notes—Lord, save him from such a fate! As was said in the first issue of THE JOURNAL under the present regime, we solicit material of every sort from our general membership. It is our province to edit such material and to determine whether it shall be used, how and when. When we use a contribution from one who is presumed to be an authority on the subject under discussion, then get "bawled out" for the opinions therein expressed, it gives us much pleasure to refer the matter to the author and let him go to it with his critic. Occasionally the ensuing battle is of the hammer-and-tongs variety, all of which pleases us greatly. We get plently of criticism, directly applied, and to have some one else take some of it is quite in order.

A VERY pertinent question in these times of industrial depression is the matter of vacations; too many of our folks seem to have omitted this in their annual budgets. We believe this omission is a very grave error; the active doctor must have rest and recreation; he cannot hope to be physically and mentally able to care for his patients if he omits this part of the annual program. Occasional week-ends to this or that nearby point is a very poor substitute for a well planned vacation of two or more weeks. With the modern road systems now to be found in every part of the country it has become a pleasure to hit the trail to some distant point, taking advantage of modern tourist camps, all with comparatively little expense. The woods of the North are calling; a recent interview with the finny tribe would seem to indicate that they are but awaiting the coming of the tourists, so there is little of conjecture about such matters; you are sure to enjoy yourself, your family will be glad to get away from the routine for a time, and you will get back on the job with more ambition and pep than you ever imagined you possessed. By all means do not neglect your annual vacation.

ONE of our active county medical society secretaries, Dr. Ivan E. Carlyle, of Sedalia, recently received a letter from a "house-organ" magazine as follows: "Dear Doctor: Will you kindly send us a copy of your society's complete schedule of fees? This is to be used in connection with a nation-wide survey we are making." To this Dr. Carlyle replied, "Your letter of the fourteenth instant came in this morning and from the tone of the last few numbers of your publication you seem to be picking the chestnuts of the Committee on the Costs of Medical Care out of the fire; and as neither the American Medical Association, the Indiana State Medical Association, the Clinton County Medical Society, nor the private physicians who compose these organizations, endorse this move toward socialism or state medicine, until so directed by the society I shall decline to forward you any information in regard to the private affairs of the members of our society." We share this secretary's opinion that there are too many uplifters from without the ranks of our profession and that they need to be made to feel that their free advice is not welcome.

THE second annual post-graduate instructional course given by the Indiana State Medical Association was held at Richmond, Indiana, on June first. While the attendance at this meeting was not so large as last year, the program was well received and those attending felt amply repaid for their time. The local organization in Richmond rendered every assistance in arranging for adequate and comfortable accommodations for the meeting. The rule which the committee followed in selecting speakers of known ability as teachers was demonstrated as being the proper procedure in preparing for this kind of a course. The difficulty, of course, in following this plan is the question of expense. Such men are usually full time or part time teachers in medical colleges and must have their expenses paid. A small registration fee will not cover this expense. Most medical programs are financed by advertising exhibits, which are not part of such a program. It would be possible to have the same man fill two or three hours and in this manner cut the number and correspondingly the expense. This type of program has demonstrated, we believe, its value to the profession, and the interest manifested would seem to indicate a demand for its continuance.

THE other day we received a clipping from a northern Indiana paper containing a story concerning the use of evaporated milk in the treatment of ulcers of the stomach; said story was based on an article in the official journal of a neighboring state. What aroused our cupidity was the fact that the single paragraph of the "news item" was accompanied by a picture of the author. The medical society of which this man is a member was approached in the matter; an investigation was made, but all to no purpose; it is no easy task to connect a physician with commercialism in these cases. The fact remains, however, that a canned milk campaign seems to be on; it is quite possible that an enterprising advertising man might sense the publicity value of an article in a medical journal and lift therefrom such parts as would best suit his case, but we cannot understand from where the picture comes. The reading public of Indiana surely is not concerned with the picture of a man merely because he recommends canned milk for gastric ulcer; the only reason for using the picture would seem to be to attract attention. This is the second instance in which we have called the attention of readers of THE JOURNAL to what might be called advertising stunts by physicians from a neighboring metropolis; when it comes to matters of publicity, Indiana needs little help from her neighbors. We have some first class exponents of that noble art within the borders of our own state; therefore we serve notice that future offenders will find their propaganda, pictures and all, printed in THE JOURNAL.

IT is quite apparent that the problem of indigent medical relief is widespread, as evidenced by the number of "plans" that have been adopted as a solution. The latest to come to our attention is the Detroit Plan, which seems to offer a very happy answer to a very grave problem. We append a digest of their plan, as it appears in the *Wayne County Medical Society Bulletin*, for June:

"Any person in need of medical service who is a resident of Detroit or Wayne County may apply either to his family doctor or to the new offices established in the Medical Society Building at Woodward Avenue and W. Canfield.

"If the prospective patient has no family physician, he will be supplied with a list of members of the Society who have offices in his neighborhood. He can make his choice from the submitted names. If he has a family doctor, he will be asked to see him first.

"If the doctor selected or the family doctor, as the case may be, can render all the service necessary, patient and doctor will agree upon a fee within the ability of the patient to pay.

"If, in addition, the services of consulting doctors, laboratory and x-ray are required, the patient will be asked to fill out a questionnaire. From the information thus supplied, an equable rate will be fixed for the services to be given.

"Deferred payments, at no interest charges, will be arranged when warranted.

"The entire cost will be based solely on the patient's ability to pay, without subjecting him to any hardship, and every effort will be made to see that he receives every necessary service."

FROM the time the 1927 drugless practitioner amendment went into effect there has been considerable misunderstanding on the part of some of our county clerks as to the manner in which the local license should be issued. In a considerable number of cases the applicant went directly to the clerk of the local circuit court, exhibited his "diploma," and thereupon was issued the necessary license, all without the knowledge of the Indiana State Board of Medical Registration and examination. Cases of this sort began to crop up here and there over the state and even now, after more than five years, we learn of such instances occasionally. One man was denied licensure by the Board on May 9, 1928; this man today has a county license, to all intents and purposes just as official as that of any other licensee in that county. The clerk seems to have admitted that the license was improperly issued, through error, but this chap still has the license and refuses to part with it. Similar cases have been discovered in various parts of Indiana during the past five years. In Porter County a man and wife were found to have licenses issued directly by the county clerk and when they were advised that these had been improperly issued they immediately surrendered them. From a personal experience of several years with the Medical Board we arrived at some very definite conclusions regarding the matter under discussion. There has been, and is at present, too much laxity in the handling of these licenses by some of our county clerks, chiefly through ignorance of the law in the matter. The clerk is handed a diploma and that part of the law referring to issuance of a county license pointed out to him; it may be that he reads only that part having to do with handing over the local license. Thus it is possible for one to obtain such a license without regard for the Medical Board, and until the matter comes to the official attention of the Board in some manner, the holder of such a license operates without molestation.

This is one of the strongest arguments for annual registration, a plan in operation in many states with the utmost of success. Under such a plan the "quick license" artist could operate but a few months at most, ere he was detected. Such a law would have operated to prevent a negro from carrying out a well-planned scheme, under which he practised medicine in one of our northern cities for some years ere he was caught. An annual registration fee of one or two dollars would hurt none of us but would serve to correct many of the abuses of the present law.

THE PRESIDENT'S PAGE

SOCIAL MEETINGS

All work and no play makes Jack a dull boy. This old adage has recently been impressed upon me since the coming of spring and summer, and I have attended so many district and county society meetings held at country clubs, country homes, or summer camps. Some of these meetings, especially the district meetings, have been an admixture of work and play. Others, particularly the county meetings, have been given over to social and play time with wives and families present. Cards, golf, horseshoes, tennis, baseball, swimming, or quiet chats have all been indulged in, not to mention food, and, last but not least, the production of increased camaraderie.

At a recent picnic meeting of the Delaware-Blackford County Medical Society, one of the members said to me, "We hold two social meetings a year to which our families are invited, one at Christmas and a picnic in June. I believe our doctors of this county are more congenial than in any other county of the state, and believe these parties deserve the credit." This is well worth considering for those counties which do not have such meetings, and especially in those counties in which the members are not so congenial as they might be. Contact socially, business competition forgotten, makes us realize that doctors are really good fellows, and I am certain it will make us less likely to drop that casual remark that may be the beginning of a malpractice suit.

POSTGRADUATE

Beyond doubt, the postgraduate course held at Richmond on June first, was a success. Exactly one hundred registered, and there was universal expression of satisfaction and request for continuation. The arrangements by and co-operation of the Wayne County physicians was all that could be asked for, and their request for a return engagement is evidence of their appreciation.

The efforts and accomplishments of the State Committee, headed by Dr. Murray Hadley, deserve the highest compliments and appreciation from the State Association. The course was interesting, instructive and practical, given by men who are masters of their subjects and competent teachers. Everyone came away richer in workable knowledge than when he went. I hope other sections of the state may have the benefit of similar courses at an early date.

SECRETARIES' INSTRUCTION

The secretaries' meeting for instruction and information relative to the reorganization and work of the State Board of Health will be held after this goes to press. It is my hope that every secretary was able to attend this meeting, for so much is going to depend upon the full understanding by and co-operation of the county secretary in carrying out and making workable the new set up. I want to urge upon any secretary who was not able to attend this meeting to get in touch with Dr. Mitchell and Mr. Hendricks and get the full report of the meeting.

FRENCH LICK

Again let me urge you to make plans to attend the state meeting at French Lick in September. The scientific program committee is completing a most interesting program, one of practical as well as scientific value. The social part will also be featured, and you can be assured of a good time as well as a profitable time.

VETERANS

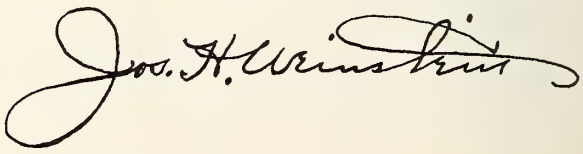
The recent legislation by Congress regarding the lessening of veteran pension cuts for service connected disabilities meets with the full approval of the medical profession. We have no case to argue against any care that should be given service connected cases, but what we must watch is the attempt by some radicals both in and out of Congress to insidiously push in an entering wedge that would ultimately bring the medical care of any veteran back to the position held before the economies instituted by President Roosevelt were established.

PUBLIC MEETINGS

After much careful thought and consideration of the report of the Committee on the Costs of Medical Care regarding its publicity by the medical profession to lay audiences, the conclusion was unanimously reached not to voluntarily discuss it in public.

The Committee on Costs planned to have the whole matter discussed and publicized by presentation before civic clubs, chambers of commerce, parent-teacher associations, etc., and should we do this, we are only furthering its ends.

We should have thorough discussion before our medical societies and among ourselves, but discreet silence at public meetings on our part will the sooner force it into the oblivion of the past. Should we be invited to make an address on the economics of medicine, there are many things that may be talked about of great benefit to both the physician and the public without discussing the committee report.



HIGH LIGHTS OF MEETING OF THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION

R. L. SENSENICH, M. D.
Indiana Member of House of Delegates
SOUTH BEND

The House of Delegates of the American Medical Association met at Milwaukee on June 12, 1933, this being the eighty-fourth annual session (the eighty-sixth year) of the Association. Speaker F. C. Warnshuis, who has for fourteen years so ably occupied this office, presided. Vice-Speaker Albert E. Bulson, deceased, so long an outstanding representative of Indiana and aggressive exponent of high standards in medicine, will long be missed in the sessions of this body.

While there is not immediately at hand information as to the variety or character of the questions submitted for consideration in the earlier meetings of this legislative body of the Association, it has been apparent in recent years that the number of questions presented has greatly increased. Progress in medicine and the necessity of co-ordination of this profession with a constantly changing public contact has been responsible for much lay and professional discussion. Complexities of a disturbed social and economic structure have recently not only added many problems but have made them generally more acute. The officers, Board of Trustees and permanent committees such as the Judicial Council, Council on Medical Education and Hospitals, Council on Pharmacy and Chemistry, and various bureaus are charged with the responsibility of investigation and administration of the various subdivisions of the work of the Association throughout the year.

The reports of these bodies together with the legislative proposals submitted to the House comprise a very large amount of material. It is only by classification of this material and division of the membership of the House into Reference Committees who may meet simultaneously that so many questions can be given consideration in the limited time available in these sessions. Committee hearings permit adequate discussion by those best informed, and the results of these deliberations are presented to the House for final action.

BUSINESS MANAGEMENT

The report of the Secretary and Board of Trustees, covering as it does the business management of the Association for the preceding year, obviously carries much of interest to the individual member of this medical enterprise. The report is much too long to comment on in detail and essential extracts were presented in the Bulletin. Suffice it to emphasize the fact that the total income exceeded total expense by $93,842.75, of which $74,967.03 was realized as interest on investments. As of December, 1932, an appraisal of these investments is reported to have shown a total depreciation of less than six per cent. It is therefore evident that, allowing for slight fluctuations in income and expense, the business is being operated without either profit or loss under present most difficult conditions. Investments and investment income continue to furnish a background for safety.

While there was reported a net loss of approximately two thousand members of the American Medical Association, it is worthy of note that the membership of the Indiana State Association is now only slightly less than it was a year ago. Judging, however, from the number of physicians listed in Indiana in the tenth edition of the American Medical Directory, it would seem that there must still be many acceptable to medical organizations who remain in that non-member group.

VETERANS' MEDICAL SERVICE

The Board of Trustees reported upon the work of its Bureau of Legal Medicine and Legislation in its successful effort in bringing to the attention of the authorities and public the excessive use of Veterans Bureau funds and facilities for care of non-service connected disabilities.

In this connection the services of many Indiana medical men must be acknowledged, those who served on local committees both within and without the Legion, those of the committee headed by Dr. J. H. Weinstein, who appeared before the committee of the House of Representatives and pointed out the extent to which the Government was entering into competition in the practice of medicine, as well as the Committee on World War Veteran Legislation of the American Medical Association of which Dr. F. S. Crockett was a member.

This contact with the veterans' medical service is to be maintained by a committee throughout the coming year, not only for the purpose of fighting against the return of abuses but also to call attention to instances where regulations promulgated may be doing injustice to those entitled to care.

The rationalization of medicinal liquor regulations was reported by the Bureau of Legal Medicine and Legislation who were active in obtaining this legislation. The report concludes: "It remains now for the profession to justify that course, not only in order that the good name of the profession may be upheld but also to avoid the necessity of the modification of the regulations toward more rigid control."

The Bureau of Health and Public Instruction reported its varied activities and referred to the new series of sex booklets by Dr. Thurman B. Rice as one of its most important publications.

Medical Economics

The Bureau of Medical Economics, whose work is now referred to as "Economics of Medical Service," has had tremendous problems thrust upon it as a result of a medical profession suddenly awakened to its economic difficulties. The Bureau in its report classified these problems as the result of (1) current social and economic conditions, (2) culmination of long-standing and gradually developing practices, (3) extension of commercialism under the guise of cures for certain alleged faults in the administration of medical service.

Research studies undertaken were (1) contract practice, (2) workmen's compensation, (3) collection methods and agencies, (4) medical economics in medical colleges, (5) group practice, (6) group hospitalization, (7) health and accident insurance practice. The results of many of these studies have been published in the JOURNAL or are available in pamphlet form and contain much valuable information.

The many problems involved in possible contractual relations of physicians to patients or to groups of patients as a result of many new schemes pressed upon the public and the physician has led the Judicial Council to further define "Contract Practice" as applied under Chapter II, Article VI, Section 2 of the "Principles of Medical Ethics," as follows: "By the term 'contract practice' as applied to medicine is meant the carrying out of an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization or individual, to furnish partial or full medical services to a group or class of individuals for a definite sum or a fixed rate per capita. Contract practice *per se* is not unethical. However, certain features or conditions if present make a contract unethical, among which are: (1) When there is solicitation of patients, directly or indirectly. (2) When there is underbidding to secure the contract. (3) When the compensation is inadequate to assure good medical service. (4) When there is interference with reasonable competition in a community. (5) When free choice of a physician is prevented. (6) When the conditions of his employment make it impossible to render adequate service to his patients. (7) When the contract, because of any of its provisions or practical results, is contrary to sound public policy. Each contract should be considered on its own merits and in the light of surrounding conditions. Judgment should not be obscured by immediate, temporary or local results. The decision as to its ethical or unethical nature must be based on the ultimate effect for good or ill on the people as a whole." The report was adopted. Dr. F. W. Cregor of Indiana, delegate from the Section of Dermatology, was a member of the council.

A very large number of resolutions presented to the House of Delegates and submitted to its Reference Committee concerned medical education and cannot be taken up in detail.

Medical Education

The report of the Council on Medical Education and Hospitals, however, contains much valuable information and is worthy of study. The following is of interest to all physicians who may advise prospective medical students. It is stated that in the ten year period past the number of medical graduates greatly exceeded the number of deaths in the profession and that the ratio of physicians to population is twice as great in the United States as in England, France and Germany. Estimates indicate, it is stated, that there is already a surplus of twenty-five thousand physicians. It is also stated that 6,335 students matriculated out of 12,280 applicants last year. Estimates are to the effect that there are not less than two thousand American medical students enrolled in France, Germany, Austria, Switzerland and Italy, largely because of inability to matriculate in American schools, and anticipating later return to this country. It is therefore pointed out that it would seem desirable for the American Medical Association to inform the public that the profession is already overcrowded and to enlist the co-operation of high schools and colleges in bringing about a substantial reduction in enrollment of medical students.

The question of certification of specialists was referred to the Council on Medical Education and Hospitals in 1931 for investigation and recommendation, looking to the establishment of proper qualifications of physicians who shall engage in special practice. The action of the House at this meeting authorized the Council to undertake this classification in co-operation with existing Boards of Certification which are acceptable to the Association. The reasons set forth in part were that "Unless the American Medical Association shall undertake to make available lists of those who conform to uniform and approved standards in the various special fields of medicine, the multiplicity of other agencies attempting to perform this service will inevitably lead to great confusion on account of the diversity of methods employed. With state legislatures, state boards, state societies, and local and voluntary organizations of every sort assuming to pass judgment on the qualifications of specialists only chaos can result."

The following were some of the many divergent subjects submitted to the House upon which action was taken as follows:

Recommended the use of surplus beds and facilities of existing army and navy hospitals for the care of veterans where such use would prove satisfactory and economical.

Cautioned against the public statement of personal opinion by medical men, which might be construed to be the expressions of organized medicine which they are not authorized to represent.

Expressed itself as deploring the actions of nations in discriminating against physicians because of their religion.

Declined to authorize the creation of a special committee on the study of contraception.

NEW OFFICERS

The election of officers of the American Medical Association resulted in the selection of Walter L. Bierring, Des Moines, Iowa, for President-elect; John H. Musser, New Orleans, Vice-President; Olin West, Chicago, Secretary and General Manager; Herman L. Kretschmer, Chicago, Treasurer; F. C. Warnshuis, Grand Rapids, Michigan, Speaker of the House of Delegates; Nathan B. VanEtten, New York, Vice-Speaker of the House of Delegates; A. A. Hayden, Chicago, Board of Trustees; C. B. Wright, Minneapolis, Board of Trustees; John H. O'Shea, Spokane, Washington, Member of Judicial Council; James S. McLester, Birmingham, Ala., Member of Council on Medical Education and Hospitals; James G. Paullin, Atlanta, Ga., Member of Council on Scientific Assembly.

« » MILWAUKEE SESSION NOTES « »

A "better feeling" that promises to mark the beginning of a business upturn was the outstanding feature of the annual session of the American Medical Association at Milwaukee, June twelfth to sixteenth. This encouraging spirit was in evidence everywhere and was sensed by the 134 Indiana physicians present. They felt it as they attended the scientific meetings, sat in on the business sessions of the House of Delegates, wandered through the interesting scientific exhibit, viewed the commercial displays or reunioned with their friends who came from all over the country to push the attendance mark close to five thousand and jam the hotel lobbies or gather in those attractive and hopitable places for which Milwaukee is duly famous and from which often comes a cheery "Prosit."

* * *

Indiana physicians played a prominent part in the scientific and business proceedings of the session. All five of the Indiana members of the House of Delegates, the governing and legislative body of the organization, were present at every session of the House. Thus they batted 1,000 per cent. These were Dr. F. S. Crockett, Lafayette, who served as head of the reference committee on the reports of officers; Dr. D. C. Cameron, Fort Wayne; Dr. H. G. Hamer, Indianapolis; Dr. R. L. Sensenich, South Bend, and Dr. Frank W. Cregor, Indianapolis, delegate from the Section on Dermatology and Syphilology.

* * *

Dr. Sensenich presented a resolution on behalf of the Indiana State Medical Association providing that medical schools include a series of lectures in their courses on ethical and economic subjects. This resolution, which was passed by the Indiana society last year, was adopted unanimously. This means that medical schools throughout the country will follow the lead of the Indiana State Medical Association and the Indiana University School of Medicine and arrange lecture courses by bankers, insurance men and business and professional men for their students. The Indiana school had a series of some twelve lectures on these subjects in the term just completed.

This resolution was originally presented to the Indiana State Medical Association by Dr. C. J. Clark, of Indianapolis.

Following tradition, immediately upon his selection, Dr. Walter Bierring, of Des Moines, Iowa, president-elect of the American Medical Association, received an invitation from the Indiana delegates to be a guest of honor at the eighty-fourth annual session of the Indiana State Medical Association, to be held September 25th, 26th, and 27th at French Lick. Dr. Bierring and Dr. Morris Fishbein, editor of the Journal of the American Medical Association, will be the principal speakers at the annual banquet the evening of September 27th.

The names of ten Indiana physicians appeared on the program: John W. Carmack, K. K. Chen, W. D. Gatch, W. N. Wishard, H. G. Hamer, H. O. Mertz, E. B. Mumford, chairman of the division of orthopedic surgery, all of Indianapolis, and Dr. M. W. Lyon, South Bend, and Floyd T. Romberger, Lafayette. In addition, Drs. K. K. Chen and A. L. Chen, of the Lilly research laboratories, had an interesting exhibit on poisonous secretions in toads, and Dr. Thurman B. Rice, of Indianapolis, had an exhibit of three-dimension models, maps, charts and diagrams showing vital statistics gathered in the last thirty-two years in Indiana.

* * *

The list of commercial firms from Indiana having exhibits follows: W. D. Allison Company, Indianapolis; Frank S. Betz Company, Hammond; DePuy Manufacturing Company, Warsaw; Domore

Chair Company, Elkhart; Emmerich-Schmind, Inc., Indianapolis; Enochs Manufacturing Company, Indianapolis; Mead, Johnson and Company, Evansville; Eli Lilly and Company, Indianapolis; Snuggle Rug Company, Goshen; Sun-Rayed Company, Frankfort, and Zimmer Manufacturing Company, Warsaw.

* * *

One of the most interesting and worthwhile meetings of the entire session, as far as Indiana was concerned, was the informal get-together of the delegates and officers of the state association who attended the convention, with Dr. E. R. Hays, of Nebraska, who puts on the annual exhibit for the Nebraska Medical Society at the state fair in Omaha, each year. Dr. Hays was guest of the Indiana delegates at an informal dinner and explained the fine work that the Nebraska Medical Society is doing each year at the annual state fair. A detailed report in regard to this will be published in a later number of THE JOURNAL.

* * *

Among the Indiana physicians present at the meeting were: Charles J. Adams, Kokomo; Max A. Bahr, Indianapolis; H. M. Banks, Indianapolis; R. D. Bayley, Lafayette; H. F. Beckman, Indianapolis; Raymond C. Beeler, Indianapolis; P. C. Bentle, Greensburg; Raymond J. Berghoff, Fort Wayne; David A. Bickel, South Bend; C. B. Bohner, Indianapolis; R. M. Bolman, Fort Wayne; E. B. Boots, Hobart; Theodore R. Borders, Fort Wayne; Eugene L. Bulson, Fort Wayne; L. W. Brown, Fort Wayne; Raymond R. Calvert, Lafayette; Don F. Cameron, Fort Wayne; Ernest R. Carlo, Fort Wayne; John W. Carmack, Indianapolis; L. D. Carter, Indianapolis; Walter Carver, Albion; E. L. Cartwright, Fort Wayne; J. V. Cassady, South Bend; Truman E. Caylor, Bluffton; K. K. Chen, Indianapolis; W. B. Christophel, Mishawaka; Cyrus J. Clark, Indianapolis; W. F. Clevenger, Indianapolis; Frank W. Cregor, Indianapolis; F. S. Crockett, Lafayette; Clyde G. Culbertson, Indianapolis; S. C. Darroch, Cayuga; Carl M. Davis, Valparaiso; Parvin M. Davis, New Albany; C. H. DeWitt, Valparaiso; W. W. Duemling, Fort Wayne; James A. Duggan, South Bend; G. P. Eckhart, Marion; Charles H. Emery, Bedford; M. A. Farver, Middlebury; J. M. Fleming, Elkhart; E. T. Gaddy, Indianapolis; W. D. Gatch, Indianapolis; Lyman K. Gould, Fort Wayne; Charles E. Gillespie, Seymour; Alfred S. Giordano, South Bend; George F. Green, South Bend; Arthur F. Hall, Jr., Fort Wayne; Hugh M. Hall, New Carlisle; H. G. Hamer, Indianapolis; C. B. Hathaway, Butler; H. J. Hiestand, Pennville; Marian Hochhalter, Logansport; J. E. P. Holland, Bloomington; J. E. Hughes, Indianapolis; W. F. Hughes, Indianapolis; George H. Kamman, Seymour; H. H. Kamman, Columbus; Thomas D. Keckick, Gary; Gerald F. Kempf, Indianapolis; Frank J. Kendrick, LaGrange; Edgar F. Kiser, Indianapolis; Harry E. Klepinger, Lafayette; M. E. Klingler, Garrett; Edward Kruse, Fort Wayne; Vincent A. Lapenta, Indianapolis; Russell W. Lavengood, Marion; D. R. Lee, Indianapolis; Arnold L. Lieberman, Gary; A. K. Logan, Petersburg; J. E. Luckey, Wolf Lake; Robert C. Luckey, Wolf Lake; Marcus W. Lyon, Jr., South Bend; Martha Brewer Lyon, South Bend; Robert J. Masters, Indianapolis; S. E. Mentzer, Monroeville; Keith T. Meyer, Evansville; J. E. McCardle, Fort Wayne; Charles O. McCormick, Indianapolis; P. E. McCown, Indianapolis; A. L. Mikesell, Fort Wayne; S. T. Miller, Elkhart; R. A. Milliken, Indianapolis; Robert M. Moore, Indianapolis; Charles A. Morgan, Indianapolis; O. B. Nesbit, Gary; Ross C. Ottinger, Indianapolis; C. R. Pettibone, Crown Point; Harold D. Pyle, South Bend; Michael E. Rafacz, Whiting; Bernard D. Ravdin, Evansville; B. W. Rhamy, Fort Wayne; Thurman B. Rice, Indianapolis; David W. Robertson, Deputy; Floyd T. Romberger, Lafayette; C. V. Rozelle, Anderson; Louis A. Sandoz, South Bend; Charles E. Savery, South Bend; Donald W. Schafer, Fort Wayne; Jacob Schlesinger, Hammond; Ada Schweitzer, Indianapolis; Russell F. Scott, Kokomo; Louis H. Segar, Indianapolis; R. L. Sensenich, South Bend; John W. Shafer, Lafayette; E. M. Shanklin, Hammond; John T. Short, Fort Wayne; David W. Sluss, Indianapolis; J. S. Spangler, Kokomo; Henry G. Steinmetz, Logansport; Urban F. Stork, Evansville; R. B. Stout, Elkhart; Dorothy D. Teal, Arcadia; M. S. Teters, Middlebury; E. F. Tindal, Muncie; H. M. Trusler, Indianapolis; Earl Van Reed, Lafayette; F. C. Walker, Indianapolis; Thomas E. Ward, Williamsport; Patrick H. Weeks, Michigan City; Henry G. Weiss, Evansville; Homer H. Wheeler, Indianapolis; H. J. White, Hammond; James M. White, Gary; Frank E. Wiedemann, Terre Haute; Matthew Winters, Indianapolis; Louis J. Wisch, Whiting; William Wise, Indianapolis; F. B. Wishard, Anderson; William N. Wishard, Jr., Indianapolis; J. G. Wright, Valparaiso.

THOMAS A. HENDRICKS.

Many problems of vast importance to every member of the profession were brought up for consideration at the House of Delegates of the American Medical Association during the Milwaukee session. Resolutions and recommendations in regard to these many problems were passed by the House of Delegates. Complete information of these will appear in the numbers of The Journal of the A. M. A. during the following few weeks.

MORE ABOUT THE FRENCH LICK SESSION

The Vanderburgh County Medical Society's softball baseball team issues a challenge to any physicians' team in the state. Game or games are to be played at French Lick. Challengers may get in touch with Dr. Keith T. Meyer, of Evansville.

* * *

This year's program includes an instructional course conducted by each section. The popularity of these instructional programs last year is the reason for their continuance this year. Worthwhile subjects have been selected.

* * *

Many physicians have the idea that French Lick is an expensive resort. This year the French Lick Springs Hotel is offering members of the Association special rates for hotel accommodations. The rates include rooms and meals. A coupon at the bottom of this page, which you may clip and use in making your reservations, will show you the rates which have been accorded us; and remember, these rates are for American plan hotel accommodations.

* * *

The usual golfer's luncheon is a part of the program of this year's convention. Besides the golf tournament, there will be a trap shoot for men.

A stag dinner, and a dinner party and entertainment for the women, will make up the program for the evening of June twenty-fifth.

* * *

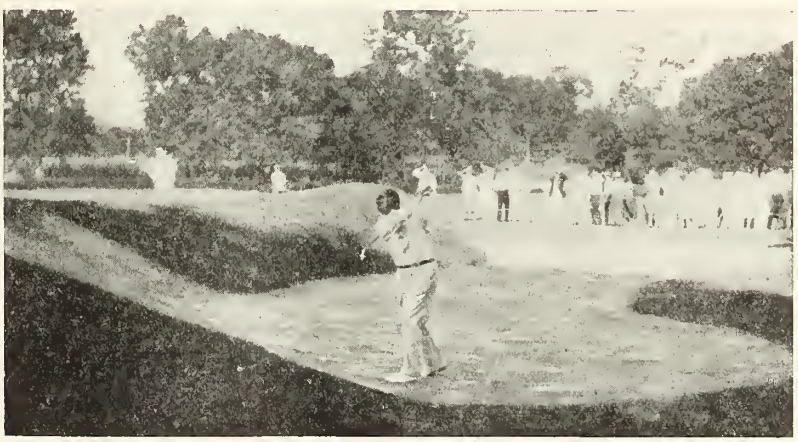
Tuesday, September twenty-fifth, there will be an economic round-table discussion. Most of the phases of medical economics will be touched upon. What are your ideas?

* * *

We have heard some comment to the effect that French Lick is a "formal" place and that everybody will be "all dressed up." We want to impress upon every member of the Indiana State Medical Association that such an idea is a grossly mistaken one. Every affair of the convention will be quite informal.

* * *

This year, through the courtesy of the French Lick Springs Hotel, the annual banquet will be free to those who are registered in the hotel. Banquet guests not registered in the hotel will be charged two dollars per plate.



French Lick Springs Hotel Golf Course

Manager, French Lick Springs Hotel,
French Lick, Indiana.

Please reserve for me, during the convention of the Indiana State Medical Association, the following accommodations, as checked:

.....rooms with bath, facing garden, at $9 per day per person, for.....persons.

.....rooms with bath, facing hillside, at $8 per day per person, for.....persons.

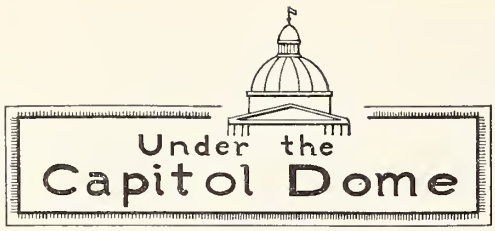
.....rooms with running water and toilet, facing garden, at $7 per day per person, for.....persons.

.....rooms with running water and toilet, facing hillside, at $6 per day per person, for.....persons.

.....rooms with running water only, 2 persons to room, $5 per day per person.

We expect to arrive on.....

Name Address



Physicians licensed to practice in Indiana since publication of the list in the June issue: Trevenning Harris, Gary; Joseph D. McDonald, Evansville; Ona V. Wilson, Evansville; Walter Breutsch, Indianapolis; George E. Ellerbrook, Vevay; Robert M. Evans, Russiaville.

* * *

Bert Anderson was fined the sum of twenty-five dollars for illegal practice of medicine in Marion. He had spent six weeks in jail before trial. All in all, the illegal practice of medicine in Marion is rather expensive. * * *

Prescriptions for a total of 70,171 pints of medicinal whisky have been issued by Indiana physicians since April first when the Indiana law permitting prescribing and sale of the whisky went into effect, according to records in the office of the state excise director. Sale of the whisky netted a tax of $17,542.75 to the state. The tax amounts to 25 cents on each pint. The records as to the amount of tax and volume of sales were checked as of June twentieth.

* * *

Dr. William R. Davidson, of Evansville, has resigned as secretary of the state board of medical registration and examination. His place in that office was filled by Dr. F. S. Crockett, of Lafayette, who is the Democratic member of the board. Although Dr. Davidson will no longer be secretary he still retains his place on the board as a member. The resignation and the succession of Dr. Crockett become effective July first.

* * *

The appointment of Miss Mildred Kosanke of Argos as the new executive secretary of the state board of medical registration and examination has been announced by Governor Paul V. McNutt. She succeeds Mrs. Myrtle Griggs who has been connected with the board for a number of years. The change became effective July first.

* * *

Hearing on revocation of license cases for two drugless physicians will be conducted by the state board of medical registration and examination on July eleventh. Both men have been convicted of performing criminal abortions. They are Dr. Walter M. Roland, who was convicted in the Fayette Circuit Court, and Dr. John R. DeRoan, who was convicted in the Marion County Criminal Court; both are serving state prison sentences.

* * *

The license of Dr. James M. Sample of Nabb, Indiana, which was revoked in 1926, was restored June nineteenth by the state medical board. Dr. Sample was convicted in the Jefferson Circuit Court of administering poison to James C. Reed, his father-in-law. The license had been revoked because Dr. Sample had been convicted of a felony.

* * *

First payment of the new state gross income tax will be due July fifteenth. Blanks will be distributed in the various counties through county officials. Taxpayers are entitled to an exemption of $166.67 on the first installment. The tax is payable on all receipts during May and June. The forms which have been prepared by the income tax department, headed by Clarence A. Jackson, are quite simple and only a few minutes will be required to fill them out properly. Complete instructions are printed as a part of the forms. If the total amount of tax due on the first installment is $10 or over the tax must be paid when the returns are filed; but where the tax due is less than that amount the taxpayer may defer payment until the time of making his annual return.

* * *

Final examinations for licenses to practice medicine and osteopathy in Indiana were taken by 122 candidates last month. The examinations were conducted by the state medical board in the assembly room of the Claypool Hotel in Indianapolis. Three of those taking the final examinations were osteopaths. Nine medical schools were represented among the candidates. They were: Indiana University School of Medicine, Indianapolis; Rush Medical College, Chicago; Northwestern University Medical School, Chicago; Washington University School of Medicine, St. Louis, Mo.; University of Louisville, Louisville, Ky.; University of Dundee, Dundee, Scotland; University of Minnesota, Minneapolis, Minn.; University of Ohio Medical School, Columbus, Ohio, and Kirksville College of Osteopathy.

The candidates were:

Samuel L. Adair, Jeffersonville; Chas. H. Ade, Lafayette; Aaron L. Arnold, Indianapolis; George Aitken, Detroit, Mich.; Eugene J. Alexander, Indianapolis; Wm. Howard Altier, Lafayette; Charles E. Baker, New York; Avey M. Baker, Orleans; George E. Barker, LaHarpe, Illinois; Russell J. Baskett, Indianapolis; Harold F. Bonifield, Warren; Paul Bornstein, Newark, N. J.; Wallace Buchanan, Indianapolis; Earl B. Cary, Terre Haute; Nellis F. Chrisman, Kirksville, Mo.; Walter D. Close, Fort Wayne; Thomas A. Cortese, Bloomington; Donald Covalt, Muncie; Donald W. Creel, Indianapolis; Lee A. Dare, Columbia City; Ernest L. Dietl, South Bend; William Deutsch, Jr., Indianapolis; David A. Dukes, Bloomington; G. W. Farrior, Tipton; Allen A. Filek, Oak Park, Ill.; Sol. Finklestein, Chicago; Mont E. Frantz, Indianapolis; N. Harry Gladstone, Fort Wayne; Wayne R. Glock, Fort Wayne; Thomas G. Graham, Jeffersonville; Charles S. Graham, Indianapolis; Wm. L. Green, Franklin; Gordon H. Haggard, Indianapolis; B. D. Harrington, Indianapolis; George A. Held, Lamar; Thomas A. Hanna, Indianapolis; Carl J. Harmon, Valparaiso; John R. Haslem, Terre Haute; Theodore R. Hayes, Indianapolis; E. V. Herendeen, Indianapolis; Charles L. Herrick, Star City; John L. Hillery, Indianapolis; George W. Hill, Indianapolis; Myron M. Hipskind, Indianapolis; Ruth M.

Hoetzer, Fort Wayne; Francis T. Hodges, Indianapolis; Lloyd J. Holladay, Lafayette; Robert D. Howell, Indianapolis; Wayne W. Houser, Hammond; Katherine Jackson, Flint, Mich.; Stephen Lee Johnson, Indianapolis; David E. Jones, Indianapolis; Kenneth M. Kahn, Evansville; Wm. R. Kelly, Indianapolis; William A. Kemp, Indianapolis; Jaek A. C. King, Fort Wayne; Nila G. Kirkpatrick, Muncie; Melvin Kirsten, East Chieago; Kenneth K. Kranig, Indianapolis; Russell W. Lamb, Amboy; James F. Lewis, Dupont; H. C. Manaugh, Minneapolis, Minn.; John R. Matthew, Gary; Wm. B. Matthew, Gary; D. S. Megenhorst, Terre Haute; Raymond Merchant, Brook; H. C. Merillat, Indianapolis; Edore I. Meyer, New York; Floyd A. McCammon, Muncie; M. M. McDowell, Indianapolis; Milton J. Miller, Evansville; Richard H. Miller, Indianapolis; John W. Morris, New Haven; James T. Morrison, Indianapolis; Floyd S. Napper, Scottsburg; Richard B. Nelson, Hammond; William H. Norman, Hope; John H. Oyer, Indianapolis; Harry C. Peffer, West Lafayette; James M. Pfeifer, Indianapolis; Geo. J. Petro, Indianapolis; Leonard F. Piazza, Indianapolis; Milton F. Popp, Fort Wayne; Thomas R. Possolt, Indianapolis; Hugh Smith Ramsey, Indianapolis; James R. Reeves, Indianapolis; Wellington W. Reynolds, Indianapolis; Helen M. Richards, Vincennes; R. Robert Richardson, Hammond; Roy R. Risk, Chicago; Herman H. Rodin, Indianapolis; Edgar H. Roehm, Indianapolis; Bernard D. Rosenak, Indianapolis; Arthur J. Roser, Indianapolis; Guy E. Ross, Anderson; George L. Sandy, Martinsville; Wm. L. Sandy, Martinsville; Gilbert F. Schneider, Evansville; Victor V. Sehriefer, Tell City; Wm. K. Sennett, Monterey; John L. Sharp, Indianapolis; Ethan E. Shrock, Kokomo; Edith Boyer Sehuman, Plymouth; William B. Sigmund, Columbus; Harry Silvan, Chicago; Kuhrman Hale Stephens, Indianapolis; Gertrude Stangle Stewart, Scottsburg; John K. Stewart, Delphi; Paul L. Stier, Indianapolis; Herbert F. Sudranski, Indianapolis; George T. Tennis, Indianapolis; Everett W. Thomasson, Leesburg; Kenneth E. Thornburg, Indianapolis; Charles E. Thorne, Vineennes; Edmund L. VanBuskirk, Fort Wayne; John I. Waller, New Castle; Roy O. Webb, Whiting; Bryce P. Weldy, Fort Wayne; Charles L. Wise, Indianapolis; John S. Woolery, Bedford; John W. Woner, Sullivan; George W. Wright, Evansville.

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Two applicants who took examinations for licenses to practice midwifery were: Bertha Gyenge of South Bend, and Fred H. Baier of Chicago.

* * *

Lucy Jane Hill, who was charged in Indianapolis in April, 1930, with practicing medicine without a license, has been convicted in the Hancock County Circuit Court where the case was venued. Her attorney has filed a motion for a new trial. No action has yet been taken upon the motion.

MEDICO-LEGAL DEPARTMENT

By ALBERT STUMP
Attorney for the Indiana State Medical Association

QUESTION: What is the law in regard to intangible tax upon notes accepted by physicians from their patients in payment of professional services?

ANSWER:

1. Where the notes are kept in the custody and possession of the physician to be collected by him.

The physician is required to pay five cents on each twenty dollars or fractional part thereof for current intangibles, and a like amount for annual intangibles. A current intangible is one which matures or is paid within one year from the date of the execution, or within a year from the date the act took effect, which was on February 28, 1933. All others are annual intangibles. This provision of the law applies to notes executed before the effective date of the act as well as those executed after the effective date of the act. The tax is paid in all cases by the attachment of stamps to the notes. The stamps should be initialed, dated and mutilated so they cannot be used again. These stamps are procurable at the County Treasurer's office, and most banks have them as a convenience to their customers.

2. Where the notes are sold to the bank and indorsed without recourse.

If notes were accepted prior to the effective date of the act and sold outright to the bank, the bank then is required to pay the tax and attach the stamps. If the indorsement in the sale to the bank is made without recourse, then the bank cannot maintain an action against the physician as an indorser of the note. The bank takes the note under such an indorsement with no liability on the part of the indorser to pay if the maker does not pay.

If the notes are made after February 28, 1933, the effective date of the tax, the physician should pay the tax and attach the stamps, and if the note then is not paid within the year from the date of the execution it becomes an annual intangible and the bank should pay the annual intangible tax.

3. Where the indorsement does not contain the provision "without recourse."

If the physician effects a sale to the bank without his indorsement containing the provision "without recourse" the physician is liable to the bank on the note in event the maker thereof fails to pay. But if the physician pays as such indorser he then has a right to proceed on the note against the maker. After he has made such payment as an indorser the physician comes into the possession of the note. Thereafter he should pay whatever intangible taxes accrue. The fact that the bank may not be able to collect from the maker of the note does not render the physician liable to the bank for the tax which has accrued up to the time the physician paid the note and accepted it as an intangible which he could enforce against the maker. All taxes accruing after the bank takes the note and before the physician pays as an indorser should be paid by the bank.

4. Where the physician delivers the notes to the custody of the bank to be held by the bank as collateral to secure any loan which may have been made by the bank to the physician.

In this situation the ownership of the notes is still in the physician and the notes are held by the bank only for the convenience of the bank acquiring the ownership in the enforcement of their collateral. The physician, still remaining the owner, has the obligation to pay the tax.

5. Where the notes are placed with the bank for collection only, the physician pays the tax.

SECRETARIES' COLUMN

The post graduate meeting held in Richmond on June the first was a success. Everyone who attended was well pleased. It is hoped that the State Association will put on one or more of these meetings in different parts of the state.

The University's post graduate course of two weeks was a success. The report of the Secretaries Conference, held at this time, will appear in the August number of THE JOURNAL.

Maternal deaths are apparently on the increase. This subject would make a good program for one or more meetings of your county society. Try it.

Malpractice suits are on the upward path; most of these are due to a casual remark made by another physician. Let us be more careful of our words, because we never can tell when we will be in the other fellow's shoes. Our ethics must be perfect if we want malpractice suits to decrease.

The course in economics given to the seniors at Indiana University this year was successful and was very helpful to the students. We can teach a great deal to medical students so that they may be taken out of the class of "suckers."

In Prague they have a savings bank by the doctors and for the doctors. This subject is fit for study, as is also their automobile club for doctors. These subjects were published in the A. M. A., about the last of May, 1933, in foreign letters.

Would it not be nice, during these times of depression, if we had taken out an annuity when we got out of medical school? And this had been a group affair in connection with the medical society? Maybe it isn't too late to start now. Perhaps some insurance company could work it out for us. In such a case there would be no need for the medical society to help its members financially, as is being done at the present time in this country.

Help your patients and help your pocket book by "selling" health examinations to your patients.

Mr. Secretary, remember that it is up to your society to put on preventive health programs in your county. The State Board of Health will assist you with literature and picture shows. Put on the programs for the service clubs and parent-teacher clubs. Do it before they ask for it. Mr. Hendricks and Dr. Harvey will give you any "dope" on the subject you wish.

A. M. MITCHELL, M. D.

DIPHTHERIA REPORT FOR MAY, 1933

Five counties (Allen, Lake, Marion, Morgan and Warren) each report one diphtheria death for the month of May. This brings the number for the year to a total of fifty-two deaths, as compared with sixty-six last year, fifty at the same period in 1931, and fifty-three in 1930. It is gratifying to note that the tendency of the disease is definitely downward at the present time. We do not mean that the battle against diphtheria is won—far from it—but the figures seem to indicate that the enemy is on the run and that is a great consolation.

It is extremely important that every case be reported. Two of the counties mentioned above as having one death last month have reported no cases during the current year. Evidently those cases were not diagnosed as diphtheria or the physician did not report his case. In either event it is an ugly reflection upon the profession of the particular county. Without reliable morbidity and mortality reports it will be very hard to control diphtheria.

The summary for the first four months of this year and the figures for the month of May are shown below:

County	*Total for 1933*	*May, 1933*
Allen	6	1
Bartholomew	1	0
Blackford	1	0
Daviess	2	0
Delaware	1	0
Dubois	1	0
Fulton	1	0
Hancock	1	0
Harrison	1	0
Howard	1	0
Jackson	2	0
Knox	1	0
Lake	2	1
Lawrence	2	0
Marion	8	1
Monroe	1	0
Morgan	1	1
Parke	1	0
Pike	1	0
Ripley	1	0
Shelby	2	0
Sullivan	3	0
Switzerland	1	0
Tippecanoe	3	0
Union	1	0
Vigo	1	0
Warren	1	1
Warrick	1	0
Wayne	1	0
Wells	1	0
Vanderburgh	1	0
	52	5

"VOICE OF THE DOCTOR"

IMPROVEMENT IN TECHNIQUE OF PREPARING NEOARSPHENAMINE SOLUTION

Here is a suggestion for the preparation of neoarsphenamine solution which may be of benefit to those in general practice or to those in the field of syphilology. This suggestion will be most beneficial to those of us who are compelled to use the sterile distilled water in ampoule form in preparing the solution.

First, sterilize a 10 or 20 cc. all glass syringe; also sterilize a 19 or 22 standard gauge, medium bevel needle; then proceed to prepare the solution. Clean the entire tip of the sterile distilled water ampoule with an alcohol sponge, and open the ampoule by filing off its tip as far down the shoulder of the ampoule as possible; next, clean the tip of the neoarsphenamine ampoule with an alcohol sponge, and file off its tip, then gently sprinkle (do not dump) the powder on the surface of the water and permit it to go into solution without agitation; slight rotation of the distilled water ampoule is permissible, but never practice shaking; the solution is withdrawn into the glass syringe by means of the attached needle; wipe off any neoarsphenamine that remains on the needle with sterile gauze; lastly, inject solution in the vein immediately.

Some of the advantages of this procedure are that it saves sterilization of medicine glass or other glass containers; it saves time; the procedure can be used in the home as well as in the office; it saves filtering because the solution is clear; it decreases lime and other sediment which might adhere to medicine glass; it decreases chances of contamination, as water is not transferred from ampoule into medicine glass.

MAX M. GITLIN, M. D.,
Bluffton.

DEATH NOTES

GEORGE W. BENCE, M. D., of Greencastle, died June fifteenth, aged eighty-six years. He had been ill for several months. Dr. Bence opened his first office in Clay County, at Carbon, in 1871, later moving to Greencastle where he practiced until failing health forced him to retire. He graduated from the Department of Medicine of the University of Virginia, at Charlottesville, in 1871.

FORBES H. BROUGHTON, M. D., of Wolcottville, died May twenty-sixth, aged eighty-four years. Dr. Broughton was a Civil War veteran. He had practiced medicine in Wolcottville for more than fifty-five years. He graduated from the Medical College of Indiana, at Indianapolis, in 1874.

JONATHAN P. WOLF, M. D., of Evansville, died suddenly, June first. Dr. Wolf was fifty-seven years of age. He had been associated with the Deaconess, St. Mary's and Walker hospitals in Evansville, where he practiced the specialty of anesthesia. He was a member of the Associated Anesthetists of the United States and Canada, a member of the Vanderburg County Medical Society, the Indiana State Medical Association, and the American Medical Association. Dr. Wolf graduated from the Medical College of Indiana, Indianapolis, in 1905.

W. C. BUTLER, M. D., of Bedford, died May nineteenth, aged seventy-six years.

E. G. REGENNAS, M. D., of Hope, died May twenty-sixth, aged eighty years. Dr. Regennas had been ill for a long time. He graduated from the Central College of Physicians and Surgeons, in Indianapolis, in 1886.

FRANK H. ROBINSON, M. D., of Delphi, died May twenty-seventh, aged seventy-five years. Dr. Robinson had served as mayor of Delphi for twenty-two years. He was a member of the Carroll County Medical Society, the Indiana State Medical Association and the American Medical Association. He graduated from the Pulte Medical College, Cincinnati, in 1881.

R. W. HARRIS, of Algiers, died June eighth, aged eighty-four years. He had practiced in Pike County for more than fifty-five years, and was active in his practice until about a year ago. Dr. Harris graduated from the Kentucky School of Medicine, Louisville, in 1877.

N. D. WOODARD, of Indianapolis, died June eighth, aged eighty-three years. Dr. Woodard graduated from the Physio-Medical College of Indiana, Indianapolis, in 1879, later was a teacher in the school and still later became its president.

ERNST G. ZIMMER, M. D., of Upland, died May thirtieth, aged seventy-four years. Dr. Zimmer was a member of the Grant County Medical Society, the Indiana State Medical Association and the American Medical Association. He graduated from the Cincinnati College of Medicine and Surgery in 1886.

MARY VAN NUYS, M. D., of Lebanon, died May twenty-sixth, aged seventy-one years. Dr. Van Nuys graduated from the Northwestern University Woman's Medical School, Chicago, in 1897.

WILLIAM H. RATCLIFF, M. D., of New Albany, died June twelfth, aged seventy-seven years. He had practiced medicine in New Albany for twenty-seven years. He was a member of the Floyd County Medical Society, the Indiana State Medical Association and the American Medical Association. Dr. Ratcliff graduated from the Southwestern Homeopathic Medical College and Hospital, Louisville, Kentucky, in 1906.

HOOSIER NOTES

DR. and MRS. P. H. SCHOEN, of New Albany, are visiting their son in Los Angeles, California.

MEMBERS of the Fort Wayne Medical Society had their annual party June eighth, in the Shrine Club rooms.

DR. AND MRS. GEORGE DEWEY have located at Pine Village, where Dr. Dewey will conduct a general practice of medicine.

A BUSINESS meeting of the Lawrence County Medical Society was held at the Country Club, Bedford, June seventh.

DR. J. K. BERMAN, of Indianapolis, is doing some postgraduate work in Europe. He will return to Indianapolis in September.

DR. B. S. CORNELL, of Fort Wayne, has moved his offices from South Fairfield Avenue to the Lincoln Bank Tower in that city.

MISS HILDA WENDT and Dr. Norman Richard Carlson, of Michigan City, have announced their marriage at Indianapolis in November, 1931.

THERE will be no meetings of the Howard County Medical Society during June, July, and August. Regular meetings will be resumed in September.

DR. JOSEPH S. SMITH, of Indianapolis, has taken over the office and entire equipment of Dr. Ernest Cooper, of Plainfield. Dr. Cooper has retired from active practice.

DR. CLARKE ROGERS, of Indianapolis, has been appointed to the Indianapolis City Board of Health to succeed Evans Woollen, Jr., who was made city controller.

DR. M. P. HOLLINGSWORTH, of Princeton, told of his recent trip to the Chicago World's Fair in an address before the Princeton Rotary Club, June twelfth.

DR. ROBERT MOORE, of Indianapolis, addressed members of the Carroll County Medical Society at Burlington, June ninth. His subject was, "The Failing Heart."

MISS MILDRED KOSANKE, of Plymouth, has been made clerk of the Indiana State Board of Medical Registration and Examination to succeed Mrs. Myrtle Griggs.

THE Kosciusko County Medical Society met at the Hotel Tavern, at Syracuse, June thirteenth, for a dinner meeting. A general discussion formed the program for the evening.

NOBLESVILLE was the meeting place of the June thirteenth meeting of the Hamilton County Medical Society. Dr. Rollin H. Moser, of Indianapolis, was the principal speaker.

DR. JOHN WHITEHEAD, of Indianapolis, was the principal speaker before the regular monthly meeting of the Hendricks County Medical Society at Danville, June sixteenth.

DR. JOSEPH H. WEINSTEIN, of Terre Haute, was one of the principal speakers at the annual convention of the Indiana Pharmaceutical Association at Lake Wawasee, June twentieth.

THE Jasper-Newton County Medical Society met with Dr. O. E. Glick, at Kentland, May twenty-sixth. Dr. Harry Mock, of Chicago, presented a paper on "Traumatic Head Injuries."

THE St. Joseph County Medical Society met at South Bend, May thirty-first. Dr. Lewis J. Pollock, of Chicago, presented a paper on "Common Conditions Met in Clinical Neurology."

NEW officers for the Fort Wayne Medical Society are: Dr. A. L. Mikesell, president; Dr. W. B. Rice, vice-president; Dr. L. P. Harshman, secretary, and Dr. E. L. Cartwright, treasurer.

DR. J. W. BOWERS and Dr. Morse Harrod, of Fort Wayne, delivered addresses before the sixty-third annual convention of the National Eclectic Medical Association, in Chicago, June 27th.

THE regular monthly meeting of the Daviess-Martin County Medical Society was held at Washington, June fifth. Dr. W. W. Hewins, of Evansville, was the principal speaker.

THE Federal Trade Commission has ordered Theronoid, Inc., to cease and desist advertising its Solenoid Belt, having so-called therapeutic and magnetic value in treating diseases.

OFFICERS elected for the Muncie Academy of Medicine, June sixth, are as follows: Dr. H. E. Bibler, president; Dr. Forest Kirshman, vice-president; Dr. John Bowles, secretary, and Dr. W. C. Moore, treasurer.

DR. WILLIAM H. KENNEDY, of Indianapolis, has been appointed chairman of the work of the American Society for the Control of Cancer in Indiana, to succeed Dr. Miles F. Porter, of Fort Wayne, who has resigned the position.

DR. RALPH WILSON, of Evansville, known as "Hoosierdom's Grappling Physician," has abandoned the wrestling profession and opened an office for the practice of medicine in Evansville, where his father, Dr. Dalton Wilson, practiced.

THE Decatur County Medical Society held its meeting at Greensburg, April nineteenth, with Dr. E. Vernon Hahn, of Indianapolis, as the principal speaker. Dr. Hahn's subject was "Surgery in Tuberculosis Cases." Attendance numbered fifteen.

DR. RICHARD L. SUTTON, of Kansas City, was a guest of the Lake County Medical Society, June tenth, when he presented an illustrated travelogue in the high school auditorium. The title of his lecture was "Snapshots from the Arctic."

REAPPOINTMENT of four members of the board of managers of the Irene Byron Sanatorium, at Fort Wayne, was made recently. Dr. A. L. Schneider, Dr. E. H. Schlegel, Martin Luecke and John H. Evans are the members of the board.

THE Fayette-Franklin Medical Society met at Magnesia Springs, near Brookville, June thirteenth. Dr. Harold M. Trusler, of Indianapolis, presented a paper on "The Reconstruction of Burns, Scar Tissue and Plastic Surgery."

SECRETARIES of county medical societies and officers of the Indiana State Medical Association met on the opening day of the postgraduate course of the Indiana University School of Medicine, June 26th. A report of this conference will be published in the August number of this JOURNAL.

MEMBERS of the Indianapolis Medical Society enjoyed their sixth annual picnic held at the Polk Sunlight Nursery Milk Farm at Greenwood, June fourteenth. A fried chicken dinner was served and entertainment provided.

MEMBERS of the Dearborn-Ohio County Medical Society met at the King Hotel, in Lawrenceburg, May twenty-fifth. This was a dinner meeting, after which questions of general interest were discussed by the physicians.

MEMBERS of the Gibson County Medical Society met at Princeton, June twelfth, to hear papers presented by Drs. K. S. Strickland, of Owensville, and M. L. Arthur, of Patoka. Subjects presented were "Diphtheria" and "Scarlet Fever."

D. APPLETON AND COMPANY and the Century Company have announced their merger into a new company named the D. Appleton-Century Company, Incorporated. The offices of the company will be located at 35 West 32nd Street, New York City.

MEMBERS of the St. Joseph County Medical Society enjoyed golf, dinner, and drama at South Bend, June seventh. In the afternoon the physicians played golf at the Coquillard Country Club, and in the evening the doctors and their wives attended a play, "The Imaginary Invalid."

THE Chalmers gold medal, awarded by the Royal Society of Tropical Medicine and Hygiene of England, will be given June fifteenth to Dr. Saul Adler, professor of parasitology at the Hebrew University; the medal will be presented at the annual meeting in England.

DR. F. A. LOOP, of Lafayette, had a front row seat during the gun battle that took place in that city when bandits were surrounded outside his office where he had played his part in trapping them when they went there for medical attention. From all reports, Dr. Loop played his difficult rôle nobly.

MEMBERS of the Porter County Medical Society met at the Hotel Lempke, Valparaiso, May thirty-first. Dr. Arthur Miller, of Hobart, was the principal speaker, his subject being "Female Sex Hormones." Attendance numbered twenty-five. Regular monthly meetings of this society will be discontinued until September.

NEW officers elected for the Eleventh Indiana Councilor District are: J. E. Yarling, M. D., Peru, president; George D. Miller, M. D., Logansport, councilor, and O. G. Brubaker, M. D., North Manchester, re-elected secretary-treasurer. The district will hold its next meeting at Wabash in October of this year.

NEW officers for the Twelfth District Medical Society, elected at the annual meeting in May, are: Dr. Walter Carver, Albion, president; Dr. Harry W. Garton, Fort Wayne, vice-president, and Dr. A. J. Sparks, Fort Wayne, secretary-treasurer. Dr. E. M. Van Buskirk, of Fort Wayne, was reappointed councilor.

IN a special session of the Delaware-Blackford County Medical Society, May twenty-third, resolutions were passed urging an anti-noise policy and asking the co-operation of the public. The resolution cites loud speakers used on the streets for advertising purposes, street barkers, automomile cutouts and other unnecessary noise-producing devices.

MISS ANNE HEYMAN was awarded the first prize of $300 for her paper on "The Bacteriology of Goiter" by the American Association for the Study of Goiter at its annual meeting in Memphis, May 15-17. The prize is awarded annually for the best paper based on original research on any phase of goiter. Miss Heyman's investigations were carried out in the Hygienic Laboratory of the University of Michigan.

MAJOR GENERAL ROBERT U. PATTERSON, surgeon general of the United States Army, stopped in Indianapolis en route from the Milwaukee session of the A. M. A. to Washington, and made an inspection of the hospital and all medical activities of Fort Benjamin Harrison. A group of Indianapolis physicians and members of the American Legion attended a reception for Major General Patterson.

THE annual fish fry of the Fountain-Warren County Medical Society was held at the Methodist Church in Covington, June eighth. Dr. Robert Moore, of Indianapolis, was the principal speaker of the evening. The public was invited to hear his talk on "Heart Disease." Physicians from all of the nearby cities attended the meeting, as the annual fry of Wabash River catfish has become very popular.

DR. VERNE K. HARVEY, of Carmel, epidemiologist for the Indiana State Board of Health for some time, has been made secretary of the Board to replace Dr. John H. Hare who has accepted an appointment as superintendent of the Evansville State Hospital. The change is effective July 1st. Additional members of the State Board of Health will be announced in the August issue.

MEMBERS of the Tippecanoe County Medical Society met at Dayton, Indiana, June eighth, for a dinner meeting. Fifty physicians were in attendance. William F. Stock, of Mead Johnson and Company, Evansville, presented pediatric and obstetrical films. A very good group of pictures was presented and enjoyed by all. A fried chicken dinner was served at the Masonic Hall with Dr. W. F. McBride as host.

THE Merck Company, of Rahway, New Jersey, has received a letter from a man in West Louisville, Kentucky, in which he tells of the finding of a can of Merck's Zinc Stearate powder in the bottom of an abandoned well, and it was thought that the can had been in the well not less than five years. When opened, a half can of water was poured out and the other half of the can full of the powder was dry and dusty. It still was "shedding water like a duck" after a period of five years.

MEMBERS of the Floyd County Medical Society met at Corydon, in the County Court House, June ninth. Dr. F. M. Applegate, of Corydon, presented a paper on "Arteriosclerosis." Dr. J. C. Bottorf, of Corydon, presented an anatomical specimen of a fetal heart and a bifurcated sternum of an infant, in which the heart protruded through the sternum and was on the exterior of the chest; the infant lived twenty-four hours.

MEMBERS of the Hancock County Medical Society met at the Bowman Hotel, Greenfield, June twelfth. A round-table discussion was enjoyed by the eight members present, and a committee was ordered appointed to co-operate with the State Board of Health, the public and other organizations relative to future activities and health meetings in the county; the county health commissioner is to be chairman of the committee.

THE names of two physicians, Dr. C. G. Mackey and Dr. H. H. Tallman, come into the conversation often whenever the tales of the Culver Bank rob-

bery and the round-up which resulted in the capture of six bandits are told. It was Dr. Mackey's car which the bandits commandeered after their own automobile was wrecked in their futile attempt to escape. Dr. Tallman's machine, which was parked in front of his house, still carries several slugs from a sawed-off shot gun which one of the bandits used freely as he and his gang rode away from the bank.

THE Wabash County Medical Society met at the Wabash County Hospital, June seventh, to celebrate the anniversary of the one hundredth year of the practice of medicine in the county. A special feature of the program was a picture, composed of ninety-two physicians who have practiced in Wabash County during the past one hundred years. These were collected and donated to the society by Dr. J. T. Biggerstaff, and the picture will be placed in the Wabash County Hospital. The program brought out the fact that the first physician located in Wabash County in May, 1833, since which time there have been 212 physicians who have practiced in the county.

THE Society of Plastic and Reconstructive Surgery, of New York City, has adopted a resolution concerning sensational and irresponsible practices in the field of plastic surgery. The erroneous ideas concerning plastic surgery as a means of improving cosmetic appearance have gained credence among the laity, and the resolution calls attention to the fact that plastic surgery is a regular surgical specialty, embracing the reconstruction of defects and malformations that interfere with normal function as well as the repair of gross cosmetic deformities. The Society condemns the performance of any plastic operations whatsoever by lay cosmeticians and the use of beauty shops, hotel suites, and convention halls for this purpose.

THE following physicians registered for the postgraduate day of the Indiana State Medical Association at Richmond, June 1:

O. O. Alexander, Terre Haute; H. E. Allen, Richmond; J. L. Allen, Greenfield; C. C. Atkins, Rushville; James F. Balch, Indianapolis; W. M. Barton, Centerville; C. W. Beane, West Manchester, Ohio; C. C. Bitler, Newcastle; Paul W. Blossom, Richmond; C. S. Bond, Richmond; F. P. Buche, Richmond; J. C. Burkle, Lafayette; J. A. Carter, New Paris; A. W. Cavins, Terre Haute; J. C. Clawson, Richmond; L. T. Coggeshall, Chicago; George A. Collett, Crawfordsville; L. T. Cox, Fountain City; C. E. Denny, Milton; F. T. DuBois, Liberty; W. M. Dugan, Indianapolis; J. E. Ferrell, Fortville; Thomas Fitz-Hugh, Jr., Philadelphia; O. P. M. Ford, Centerville; John M. Fouts, Richmond; Earl R. Gibbs, Wilkinson; V. C. Griffis, Richmond; Harvey Hadley, Richmond; Murray N. Hadley, Indianapolis; F. E. Hagie, Richmond; W. H. Hawley, College Corner, Ohio; G. R. Hayes, Richmond; P. G. Hill, Cambridge City; C. R. Hoffman, Richmond; E. E. Holland, Richmond; Arvin Henderson, Ridgeville; R. L. Hiatt, Richmond; Gayle J. Hunt, Richmond; W. G. Huffman, Richmond; C. J. Hufnagel, Richmond; W. D. Inlow, Shelbyville; George E. Iterman, Newcastle; Paul S. Johnson, Richmond; W. F. Johnston, Richmond; L. E. Jordan, Lynn; J. E. Keeling, Waldron; Lee Keidel, Cleves, Ohio; F. E. Keith, Richmond; R. O. Kennedy, Rushville; Samuel Kennedy, Shelbyville; W. H. Kennedy, Indianapolis; R. E. Kinneman, Greenfield; J. Klepfer, Richmond; H. C. Kraft, Noblesville; F. W. Krueger, Richmond; J. B. Loving, New Goshen; Stephen C. Markley, Richmond; Elwood J. Meredith, Richmond; W. A. Miller, Hagerstown; W. L. Misener, Richmond; R. M. Moore, Indianapolis; F. T. Moore, Muncie; R. D. Morrow, Connersville; W. A. Morrow, R. R., Connersville; H. W. MacDonald, Newcastle; Walter McFadden, Shelbyville; W. B. McWilliams, Richmond; C. E. Newbold, Eaton, Ohio; G. L. Perry, Portland; Edward M. Pitkin, Martinsville; M. C. Pitkin, Martinsville; Walter L. Portteus, Franklin; L. B. Rariden, Greenfield; F. T. Romberger, Lafayette; Harry P. Ross, Richmond; Roy E. Shanks, Rushville; L. A. Smith, Indianapolis; L. A. Stamper, Cambridge City; A. A. Swope, Crawfordsville; B. M. Taylor, Portland; W. R. Taylor, Richmond; W. R. Tindall, Indianapolis; Charles Titus, Wilkinson; H. W. Thompson, Richmond (dentist); W. A. Thompson, Liberty; C. M. Treffinger, Eaton, Ohio; George W. Wallage, Middletown; J. H. Warvel, Indianapolis; Arthur S. Whallon, Richmond; H. H. Wheeler, Indianapolis; William Wise, Indianapolis; G. H. Wisener, Richmond.

IN addition to the articles already enumerated the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

Lederle Laboratories, Inc.

- Ampules Glucose (U. S. P. Dextrose) Solution-Lederle, 20 cc.
- Ampules Glucose (U. S. P. Dextrose) Solution-Lederle, 50 cc.
- Ampules Glucose (U. S. P. Dextrose) Solution-Lederle, 100 cc.

Parke, Davis & Co.

- Antipneumococcic Serum (Felton) Type I.
- Erysipelas Streptococcus Antitoxin Refined and Concentrated—P. D. & Co., 20 cc. syringe package.
- Sal-Ethyl Carbonate
 - Tablets Sal-Ethyl Carbonate, 1 gr.
 - Tablets Sal-Ethyl Carbonate, 5 grs.
 - Tablets Sal-Ethyl Carbonate with Amidopyrine.

INDIANA UNIVERSITY NEWS NOTES

AMONG the recipients of degrees at the 104th annual commencement exercises of Indiana University Monday, June 12, were the following students from the medical, nursing, and dental divisions of the University: M. D. degree, 112 (10 of whom received the M. D. degree cum laude); 48 B. S., medicine; 40, doctor of dental surgery, and 25, graduate nurse.

Doctors who received the M. D. degree, cum laude, were as follows: William E. Barnett, Logansport; Olga M. Bonke, Indianapolis; Dale D. Dickson, Letts; Charles K. Hepburn, Indianapolis; Warren R. Hickman, Logansport; Robert E. Lyons, Jr., Bloomington; Ralph J. McQuiston, Franklin; Edwin Perrin, Clyde, O.; Otto F. Rogers, Bloomington; and Yudell K. Slocum, Brooklyn, N. Y.

Students receiving the M. D. degree were Charles Ade, Lafayette; George Aitken, Indianapolis; Eugene Alexander, Evansville; Aaron Arnold, Indianapolis; Avey Baker, Orleans; Russell Baskett, Jonesboro; Robert Blondis, Cleveland, O.; Harold Bonifield, Warren; Paul Bornstein, Paterson, N. J.; Edith Boyer, Plymouth; Wallace Buchanan, Indianapolis; Howard Byrn, Terre Haute; Walter Close, Fort Wayne; Thomas Cortess, Louisville, Ky.; Donald Covalt, Muncie; Lee Dare, Columbia City; William Deutsch, Jr., Muncie; Ernest Dietle, Lakeville; David Dukes, Bloomington; Sol Finkelstein, New York City; Martin Flom, Nekoma, N. D.; Naf Gladstone, Fort Wayne; Charles Grahame, Indianapolis; Wayne Glock, Fort Wayne; William Green, Franklin; Gordon Haggard, Indianapolis; Thomas Hanna, Bloomington; Carl Harmon, Valparaiso; Theodore Hayes, Springport; George Held, Lamar; Elbie Herendeen, Indianapolis; Charles Herrick, Star City; George Hill, Indianapolis; John Hillery, Muncie; Myron Hipskind, Richmond; Frances Hodges, Indianapolis; Ruth Hoetzger, Fort Wayne; Lloyd Holladay, West Lafayette; Wayne Houser, Hammond; Robert Howell, Greencastle; Stephen Johnson, Richland; David Jones, Indianapolis; William Kelley, Bloomington; William Kemp, Richmond; Nila Kirkpatrick, Muncie; Melvin Kirkstein, East Chicago; Kenneth Kraning, North Manchester; Russell Lamb, Amboy; James F. Lewis, Jr., Dupont; Floyd McCammon, Muncie; Mordecai McDowell, Bruceville; John Matthew, Gary; William B. Matthew, Gary; Herbert Merillat, Fort Wayne; Dennis Negenhardt, Center Point; Edore Meyer, New York City; Milton Miller, Evansville; Richard Miller, Fort Wayne; Jean Morris, New Haven; James Morrison, Greensburg; Floyd Napper, Scottsburg; Richard Nelson, Hammond; William Norman, Hope; John Oyer, Fort Wayne; Harry Peffer, Jr., West Lafayette; George Petro, Martinsville; James Pfeifer, Arcola, Ill.; Leonard Piazza, Indianapolis; Thomas Possolt, West Terre Haute; James Reeves, Indianapolis; Wellington Reynolds, Buffalo, N. Y.; Helen Richards, Vincennes; Russell Richardson, Hammond; Herman Rodin, South Bend; Edgar Roehm, Indianapolis; Bernard Rosenak, Terre Haute; Arthur Roser, Huntertown; Guy Ross, Anderson; William Sandy, Martinsville; Gilbert Schneider, Evansville; Louise Schnute, Evansville; Victor Schriefer, Tell City; William Sennett, Monterey; John Sharp, Westport; Ethan Shrock, Bennetts Switch; Gertrude Stangel Stewart, Scottsburg; Kuhrman Stephens, Indianapolis; John Stewart, Delphi; Paul Stier, Fort Wayne; Herbert Sudranski, Indianapolis; George Tennis, Hymera; Everett Thomas, Leesburg; Kenneth Thornburg, Muncie; Charles Thorne, Vincennes; Edmund Van Buskirk, Fort Wayne; John I. Waller, Sullivan; Charles Webb, Sullivan; Roy Webb, Whiting; Bryce Weldy, Fort Wayne; Charles Wise, Indianapolis; John Woner, Sullivan; John Woolery, Bedford; Jonathan Yoder, Goshen.

Students awarded the doctor of dental surgery degree were: Maurice McIntyre, Indianapolis; Herman Wolfe, Vincennes; Robert Lord, Kewanna; Miles Barton, Jonesboro; Roscoe Smith, Noblesville; Carroll Shearer, Fort Wayne; Glen Spinning, Indianapolis; Floyd Steckman, Plymouth; Leif Steenerson, Climax, Minn.; Ralph Stucky, Cleveland, O.; Hector Hickman, Martinsville; Dale Hinesley, Sheridan; Ferral Hodson, Mooreland; Harold Hutson, Newcastle; Glenn Dell, Lansing, Mich.; Delbert Crider, Frank Hensley, Boston; Lowell Grant, Columbia City; Hugh Enyart, Indianapolis; Charles Jefferies, Detroit, Mich.; Victor Jordan, Jr., Evansville; Lester Kaler, South Whitley; Irving Kurtz, Jersey City, N. J.; Ralph Bobbitt, English; Paul Purman, Monroeville; George Myers, Columbus; John Puckett, Winchester; Charles Roush, Marion; Henry Wills, Connersville; Neville Boone, Laconia; Leonard Robinson, Valparaiso; Joseph Rogers, East Chicago; Edward Budnick, Detroit, Mich.; Irving Quellman, Brooklyn, N. Y.; Gilbert Quinn, Madison; Raymond Bratton, Gary; Robert McKee, Ashland, Ky.; Bernard LeFrak, Brooklyn, N. Y.; Albert Lilly, Portsmouth, O., and Ralph Marlowe, Greensburg.

Graduate nurse degrees were awarded to Mary Adams, Danville; Margaret Bixler, Indianapolis; Kathryn Boyd, Franklin; Alice Brettschneider, Gary; Florence Byal, Upland; Helen Coppock, Jonesboro; Marcia Dillinger, French Lick; Ethel Earle, Bloomington; Dorothy Hayes, Odon; Hazel Hoaglin, Crawfordsville; Ruth Hoaglin, Crawfordsville; Helen Key, Princeton; Marjorie LeMasters, Waldron; Florence Lesher, Union City; Wilma McClintock, Bloomington; Grace Miller, Upland; Mary Pigg, Indianapolis; Pauline Pitman, Royal Centre; Helen Rhoadarmer, Greenfield; Ethel Tucker, Connersville; Wilma Watt, Oakland City; Nellie White, Indianapolis; Opra Wright,

Indianapolis; Ruth Zike, Morristown, and Edith Younken, Frankfort.

Students who received the B. S. degree in medicine were: Ralph Arisman, Elkhart; Theodore Arlook, Elkhart; Lowell Beggs, Scottsburg; Clarence Bosselman, Fort Wayne; Robert Brosius, Fort Wayne; Vance Chattin, Bloomington; Charles Cook, North Manchester; Donald Covalt, Muncie; Kermit Covell, Angola; James Crawford, Indianapolis; Jack Dittmer, Kouts; David Dukes, Bloomington; Aubrey Elsten, Lapel; Elvin Fitzsimmons, Evansville; Adolph Goldstone, Gary; Clarence Haslinger, Indianapolis; Robert Hill, Bloomington; Myron Hipskind, Richmond; John Jackson, Aurora; Francis Jones, Indianapolis; Robert Kinzel, Indianapolis; Philip Kurtz, Indianapolis; Joseph Lang, South Bend; Glen Lee, Indianapolis; Edward McArdle, Fort Wayne; Robert McElroy, Scotland; John R. Matthew, Gary; Milton Miller, Evansville; Virgil Miller, Rochester; Warren Morris, Aurora; Walfred Nelson, Gary; Harold Nisenbaum, Indianapolis; William Orr, Dunkirk; John Pennell, Kokomo; Arthur Rosenthal, Indiana Harbor; Irwin Rosenthal, Indiana Harbor; Theodore Ross, Kokomo; Burton Scheib, South Bend; Gilbert Schneider, Evansville; Michael Shellhouse, Gary; Meyer Shipman, Paterson, N. J.; Homer B. Shoup, Sharpsville; Morris Stern, New York City; Albert Stouder, Andrews; Howard Sweet, Richmond; Edward Voges, Terre Haute; George Wagoner, Burrows; Robert Wiseheart, North Salem.

BOOK REVIEWS

Books received since June 1, 1933:

THE COLLECTED PAPERS OF THE MAYO CLINIC AND THE MAYO FOUNDATION: Volume XXIV—1932. Edited by Mrs. Maud H. Mellish-Wilson and Richard M. Hewitt, B. A., M. A., M. D. Octavo of 1,205 pages with 233 illustrations. Philadelphia and London: W. B. Saunders Company, 1933. Cloth, $11.50 net.

* * *

SURGICAL ANATOMY. By C. Latimer Callander, A. B., M. D,. F. A. C. S., Assistant Clinical Professor of Surgery and Topographic Anatomy, University of California Medical School; Associate Visiting Surgeon to the San Francisco Hospital. With a foreword by Dean Lewis, M. D., Sc. D., LL. D., F. A. C. S. 1,115 pages with 1,280 illustrations, some in colors. Philadelphia and London: W. B. Saunders Company, 1933. Cloth, $12.50 net.

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MINOR MALADIES AND THEIR TREATMENT. By Leonard Williams, M. D. Sixth edition. Cloth. 420 pages. Price $3.75. William Wood and Company, Baltimore, 1933.

* * *

DIET IN SINUS INFECTIONS AND COLDS. By E. V. Ullmann, M. D., instructor at the First Medical Clinic at the University of Vienna. Recipes and menus by Elza Mez. 166 pages. Cloth. Price $2.00. The Macmillan Company, New York, 1933.

* * *

OBSTETRICS AND GYNECOLOGY. Volume I. By 80 Specialists. Edited by Arthur Hale Curtis, M. D., Professor and Head of the Department of Obstetrics and Gynecology, Northwestern University Medical School; Chief of the Gynecologic Service, Passavant Memorial Hospital, Chicago, Ill. Complete in 3 volumes and separate desk index. 3,500 pages with 1,664 illustrations, many in colors. Philadelphia and London: W. B. Saunders Company, 1933. Per set, cloth, $35.00 net.

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SURGICAL PATHOLOGY. By William Boyd, M. D., M. R. C. P. Ed., F. R. C. P. Lond., Dipl. Psych., F. R. S. C., Professor of Pathology, University of Manitoba; Pathologist to the Winnipeg General Hospital, Winnipeg, Canada. Third edition, thoroughly revised. 866 pages with 477 illustrations and 13 colored plates. Philadelphia and London: W. B. Saunders Company, 1933. Cloth, $10.00 net.

* * *

BOOK REVIEWS

THE LAW AGAINST ABORTION. Its perniciousness demonstrated and its repeal demanded. By William J. Robinson, M. D. 123 pages. Cloth. Price $2.00. The Eugenics Publishing Company, Inc., New York, 1933.

Dr. Robinson's contention is that there should be a "complete and total abrogation of any law against abortion." This he claims would make possible the righting of all the sorrows and sufferings due to unwanted and untimely pregnancies. In like manner, in the face of so much financial suffering, much of it due to lack of judgment and poor planning in spending money, I wonder if it would not be reasonable to abrogate all laws dealing with stealing or the robbing of banks?

There is no doubt that there is a real problem but, with the present state of the public mind and general opinion of the profession regarding abortion, promiscuous easily-induced abortions would not help the moral situation.

The book is written to a lay public rather than from a scientific standpoint. There is nothing in it of which the profession is not well aware. Dr. Robinson has no doubt done much to keep the truly important subjects of prevenception, as he terms it, or birth control, and the apparent and real condition of enforced pregnancies before the public eye. Even physicians sometimes do not like truths whose contemplation ends in headaches rather than solutions.

The approach here is unattractive. In the first place, the bookbinding, paper, and printing are not inviting, and in the second place, the subject matter does not give the impression of careful preparation. Sentences such as, "I know a woman who can always abort herself by jumping off half a dozen times from a table," do not give the impression of well prepared writing.

There is no index nor is one badly needed.

* * *

TEN YEARS OF OBSTETRICS AND GYNECOLOGY IN PRIVATE PRACTICE. A clinical report of 1,750 obstetrical and 1,345 gynecological cases, with comparative analyses of many of the larger groups, and detailed case histories of some of the more important and less common conditions. By John L. Rothrock, A. B., M. D., F. A. C. S., formerly associate professor of obstetrics and gynecology, University of Minnesota. 209 pages. Illustrated. Cloth. Price $3.00. Paul B. Hoeber, Inc., New York, 1933.

This is a monograph of one man's experience which is enjoyable to read. There are many excellent text books of obstetrics and gynecology but to the clinician the small readable monographs are welcome. The cases reported here are from private practice whereas the usual reports are of clinic patients.

The general plan is statistical but detailed treatments are taken up in case history reports.

There are good discussions of the common disorders met with: the toxaemias of pregnancy; forceps deliveries, especially by the Kielland forceps; Caesarean section, especially by the extraperitoneal section; displacements of the uterus; and fibroid tumors of the uterus. There is a statistical summary of all cases treated at the end of each of the two parts.

The author's methods are conservative and his results bespeak his apparent good judgment.

The general make-up of the book is very attractive.

WOMAN'S AUXILIARY

The Woman's Auxiliary to the American Medical Association is divided into four sections; Indiana is included in a section of ten central states, of which Mrs. M. L. Martin, of Albany, Missouri, is divisional press and publicity chairman. Clippings concerning the publicity of the memorial planting at the Indianapolis City Hospital, and the program for its presentation and dedication, were sent to Mrs. Martin for her scrap-book. In a letter to Mrs. Charles Voyles, our state president, Mrs. Martin commended the Auxiliary and states that it was the finest project undertaken by any Auxiliary of the section.

The Auxiliary to the Indianapolis Medical Society also acted as patronesses for the first annual concert given by the nurses' chorus of the Methodist Hospital, Wednesday, June seventh, at the John Herron Art Institute.

We again beg all county Auxiliary presidents and secretaries to send in news items of their members and auxiliaries for publication in this column.

SOCIETIES AND INSTITUTIONS

INDIANA STATE MEDICAL ASSOCIATION BUREAU OF PUBLICITY

April 27, 1933.

Present: William N. Wishard, M. D., chairman; J. H. Stygall, M. D., and T. A. Hendricks, executive secretary.

Release for publication in Saturday afternoon papers, May 6, "Vacations and Typhoid," read, corrected and approved.

Radio release, Saturday, April 29—"Healthy Days Are Here Again."

Clipping from newspaper in regard to a machine creating artificial fever for patients suffering from paresis and other diseases brought to the attention of the Bureau. The Bureau was of the opinion that it is much better form to have such articles appear in reputable medical journals before their appearance in the public press.

The pamphlet distributed by the American Hospital Association entitled "The Periodic Payment Plan for the Purchase of Hospital Care," brought to the attention of the Bureau. The Bureau suggested that this pamphlet, along with the correspondence from the Hospital Association and the Bureau of Medical Economics of the American Medical Association, should be brought to the attention of a member of the Bureau who was assigned to study this matter. This correspondence contained a copy of a resolution favoring group practice which was adopted by the American Hospital Association but which is disapproved by the Bureau of Publicity as not being in harmony with the attitude of the medical profession.

Advertisements and the report of the Bureau of Investigation of the American Medical Association upon "Crazy Crystals," a drink which it is claimed has certain health giving properties, reviewed by the Bureau. Again the Bureau wishes to emphasize that the public needs protection from such advertising schemes of products that claim to do more than they may be depended upon to do. A complete review of "Crazy Crystals" is given in the March 11 number of *The Journal* of the American Medical Association.

The Better Business Bureau Bulletin containing an article on "Germania Tea" which is being sold as an obesity cure, brought to the attention of the Bureau. The same comment of the Bureau which applies to "Crazy Crystals" applies to "Germania Tea." The Better Business Bureau Bulletin, quoting from the American Medical Association, says in regard to "Germania Tea:"

"It is apparent that the physiologic effect of taking Germania Herb Tea will be that of taking senna. . . . The persistent and indiscriminate use of purgatives as a means of reducing weight is not only irrational but dangerous. Whatever may be brought about by such means is due to the fact that the food is hurried through the intestinal tract before it can be properly assimilated. In other words, a certain amount of food is totally wasted, while at the same time the digestive apparatus—and especially the lower bowel—is subjected to constant and repeated physiologic insults by the purgative."

May 5, 1933.

Present: William N. Wishard, M. D., chairman; J. H. Stygall, M. D.; E. D. Clark, M. D., and T. A. Hendricks, executive secretary.

Release for publication in Saturday morning papers, May 13, "Keep Your Eye on the Ball," read, corrected and approved.

Radio release, Saturday, May 6, "Vacations and Typhoid."

Request for speaker:

May 3—Lawrence County Medical Society, Bedford, Ind. Speaker on "Medical Economics in the Care of the Indigent" obtained.

The executive secretary made a verbal report upon the Tri-State Hospital Association meeting which was held at Chicago on May 4.

One member of the Bureau made a verbal report upon the periodic payment plan of the American Hospital Association.

The Bureau felt that several articles in regard to periodic health examinations should be prepared.

INDIANA STATE MEDICAL ASSOCIATION EXECUTIVE COMMITTEE

May 12, 1933.

Roll call showed the following present: W. H. Kennedy, M. D., chairman; H. H. Wheeler, M. D.; J. H. Weinstein, M. D.; O. O. Alexander, M. D.; E. E. Padgett, M. D.; A. F. Weyerbacher, M. D.; Albert Stump, attorney, and T. A. Hendricks, Executive Secretary.

Membership Report

Number of members on April 29, 1933	2,313
Numbers of members on April 29, 1932	2,588
Loss over last year	275
Number of members on May 12, 1933	2,396
Number of members on May 12, 1932	2,621
Loss over last year	225
(Shortage April 4 was 276)	
Number of members on December 31, 1932	2,722

The attorney for the Association was asked to prepare an opinion for the next meeting of the committee as to whether or not, according to the Constitution and By-Laws, a man can send a check for his dues direct to headquarters office instead of sending it to his county society secretary, and whether or not the headquarters office can send the membership card direct to the member, without first being requested to do so by the county society secretary.

1933 Convention, French Lick, September 25, 26 and 27

(1) The president and the secretary reported that the preliminary program and arrangements for the convention were progressing satisfactorily.

(2) In order to save an expense of some $250.00, a shift has been made in the exhibit space floor plan.

(3) New form of program. Information in regard to the relative cost of the Indiana printed program with the printed convention programs used by the Minnesota State Medical Society to be presented at the next meeting of the committee.

(4) Contract in hands of Mr. Fawcett, French Lick Springs Hotel manager, for signature, will be presented at the next meeting of the Executive Committee for final approval.

(5) Badges. After consideration of all convention badges, the same badge as used last year, offered by the Benham-Pray Company, with appropriate changes, approved for French Lick convention.

University Hospitals

(1) Admission of patients to Riley Hospital. Report of Public Relations Committee in regard to this appeared in the May JOURNAL.

(2) Use of rooms for private patients in the University Hospitals. Public Relations Committee asked to make a report in regard to this at next meeting of Executive Committee. If there is anything in the law which makes it obligatory for the University Hospitals to maintain these rooms for private patients, the committee feels that this should be brought to the attention of the Legislative Committee for action at the next session of the General Assembly. Dr. Weinstein spoke of the fact that in the present law whenever a patient is committed to one of the University Hospitals a $3.00 fee is allowed by the county judge to the physician and a $5.00 fee for the clerk of the court.

(3) A letter was received from Dr. F. S. Crockett, of Lafayette, past president of the Association, stating that the report of the Public Relations Committee was incomplete as it did not contain reference to the law recently passed by the Legislature giving the county judge the option of whether or not patients could be sent to the Riley Hospital. The Executive Committee authorized the secretary to issue a bulletin to the county society secretaries calling their attention to this new law.

New Set-up of State Board of Health

Preliminary description of new set-up of State Board of Health carried in May number of THE JOURNAL.

(1) Report made that laboratory men had met with representatives of the State Board of Health and were working out rules and regulations. Committee also working on venereal disease prevention features.

(2) A meeting on the child health and welfare feature is to be held May 14, at which time committees are to be appointed to map out a suitable program.

(3) The following letter was received from Dr. Olin West, secretary and general manager, American Medical Association, in regard to this new set-up of the State Board of Health:

"I have just received a letter from Miss Toman to which is attached a page proof of an article on the reorganization of the Indiana State Board of Health that will appear in a forthcoming number of the JOURNAL of the Indiana State Medical Association.

"I have read this statement with a very genuine interest, and I sincerely hope that the reorganization which seems to have been effected in Indiana will produce results that will bring great benefits both to the public and to the medical profession in your state.

"Just between us, my feeling is that the success of the new movement will depend very largely on the extent to which the physicians of Indiana will engage in the every day practice of preventive medicine. If the practicing physicians in any state do not see to it that the work of immunization is properly done, it is inevitable that it will be done by the state."

What Is a Clinic?

Dr. O. O. Alexander to prepare material on this subject which is to be submitted to the editor of THE JOURNAL.

Bloomington Mutual Health Association

The informal statement of the Bureau of Publicity in regard to this follows:

"The Bureau of Publicity of the Indiana State Medical Association believes that such an organization as the Bloomington Mutual Health Association is not, in the judgment of the Bureau, in conformity with the Code of Ethics of the American Medical Association and the principles of the Indiana State Medical Association; that the Bloomington physicians have no assurance that the financial part of the scheme will work out as anticipated, and the Bureau is quite sure that were the matter presented to the House of Delegates of the Indiana State Medical Association, it would be disapproved. The Bureau, therefore, unanimously disapproves the proposed scheme."

Group Hospitalization

(1) Letter received from Albert G. Hahn, executive secretary of the Indiana Hospital Association, stating that he desired to co-operate in any way possible with the State Medical Association. The Executive Committee instructed the secretary to answer Mr. Hahn's very generous letter, expressing appreciation and stating that the Indiana State Medical Association was opposed to all group hospitalization plans that had been brought forward to date.

(2) Tri-State Hospital Association meeting. Joint meeting of Illinois, Indiana, and Wisconsin hospital associations at Chicago, May 3. Representatives of Executive Committee who attended that meeting made a report to the committee. It is interesting to note that the views of many hospital superintendents apparently have changed in the last few months in regard to the absolute necessity of having some sort of a plan for group hospitalization.

(3) Letter received from Dr. R. G. Leland, director, Bureau of Medical Economics, American Medical Association, in regard to the recommendation of the trustees of the American Hospital Association concerning group hospitalization. Dr. Leland's letter says in part:

"We are not convinced that periodic payment plans for the purchase of hospital care are needed in all parts of the country. Nor are we willing to subscribe to the belief that these hospital payment plans are devoid of difficulties and dangers to the hospitals as well as to the medical profession. We have urged the greatest care in scrutinizing these plans and have always raised the questions of legality and ethics. The legality will depend somewhat upon the existing statutes in your state and the interpretation of them. I am personally convinced that these plans involve a definite question of the principles of ethics pertaining to solicitation.

"There is a tremendous amount of pressure being brought to bear on hospitals in almost all sections of the country to adopt some kind of artificial and in most instances hastily and poorly conceived plans which, in my opinion, will involve hospitals and the medical profession in schemes which in a few years they will wish to discard. The final decision for Indiana will of course rest with the profession and the hospitals there."

Better Business Bureau

Letter received from Better Business Bureau asking the State Medical Association to join the Better Business Bureau of Indianapolis at a fee of $12.00 a year. The Executive Committee moved that this be taken up at the next meeting of the Council.

Medical Defense

(1) Report prepared by headquarters office at the request of Dr. Sterling P. Hoffmann, Fort Wayne, chairman of the Special Medical Defense Committee, brought to the attention of the committee.

INDIANA STATE BOARD OF HEALTH

DEPARTMENT OF COMMUNICABLE DISEASES

Monthly Report, May, 1933

Morbidity reports from health officers, physicians, hospitals, and state institutions show a total of 2,611 reportable diseases in the state for the current month; 1,852 cases from the urban and 759 cases from the rural population. Every county in the state reported either negative or positive.

A summary of the current prevalence of diseases from the rural and urban population is as follows:

Diseases	Total	Urban	Rural
Tuberculosis	59	22	37
Chickenpox	460	346	114
Measles	1,173	920	253
Scarlet Fever	425	277	148

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Smallpox	4	3	1
Typhoid Fever	29	19	10
Whooping Cough	91	85	6
Diphtheria	65	37	28
Influenza	94	6	88
Pneumonia	23	6	17
Mumps	169	123	46
Poliomyelitis	9	2	7
Meningitis	10	6	4
Total	2,611	1,852	759

Diphtheria. A favorable decrease was noted in the incidence of this disease during May. There were 80 cases reported during April, and 91 cases during May of 1932.

Scarlet Fever. The total of 425 represents a little better than 50% decrease of the number of cases of scarlet fever reported during the current month, as compared with the previous month when 944 cases were reported.

Measles. This disease shows a greater prevalency as compared with the month of April when 817 cases were reported. Out of the total of 1,173 cases for the current month, 920 cases were from urban vicinities, 586 cases occurring in Indianapolis.

Smallpox. For smallpox the comparison of the incidence is the lowest in the history of the Department. A total of only 4 cases for the entire state during the current month is very gratifying.

Influenza. As might be expected, the prevalence of influenza showed a seasonal decrease this month, there being only 94 cases reported. During the previous month there were 146 cases reported.

Meningococcus Meningitis. Compared with recent months, meningitis is slowly approaching a new low level. Indianapolis reported 6 cases of this disease out of a total of 10; the remainder being one each from Adams, Greene, Hancock, and Knox counties.

Typhoid Fever. A very noticeable increase in this disease was shown for the current month, there being a total of 29 cases, as compared with 8 for the corresponding month of last year, and 8 for the previous month. Out of the total given, 10 cases were reported from Bicknell (Knox County). Investigations are being conducted regarding the apparent epidemic of this disease in Bicknell at the time of the writing of this report.

The name and number of diseases not mentioned above that were reported during May are as follows: tuberculosis, 59; chickenpox, 460; whooping cough, 91; pneumonia, 23; mumps, 169; and poliomyelitis, 9.

THURMAN B. RICE, M. D., *Director.*

NINTH DISTRICT MEDICAL SOCIETY

The Benton County Medical Society was host to the Ninth District Medical Society at Hazelden, the country home of George Ade, Brook, Indiana, on May twenty-third, 1933.

A golf tournament was held in the morning. The meeting of the county delegates convened in the dining room of Mr. Ade's home. During luncheon Mr. Ade entertained the delegates with reminiscences of Drs. John B. Murphy, Frank Billings, and General Gorgas, all of whom were personal friends of his.

Interesting papers were given at the scientific session by Drs. Rollin T. Woodyatt and Edwin Miller, of Chicago, and Dr. J. O. Parramore, of Crown Point. Dr. Miller capably substituted for Dr. Vernon David, who because of illness was unable to be present. Mr. Thomas Hendricks in an interesting and enlightening talk touched upon numerous subjects of interest to the society.

After dinner talks were made by Dr. L. D. Moorhead of Chicago and by Mr. Ade. The remainder of the evening was spent in informal dancing. Autographed copies of Mr. Ade's "The Microbe's Serenade" were given as souvenirs.

The Clinton County Society will entertain the District Society, in 1934, at Frankfort.

Dr. S. B. Sims, of Frankfort, was elected president for the coming year and Dr. Ivan E. Carlyle, of Sedalia, was elected secretary-treasurer. Both elections were unanimous.

THOMAS L. KEEFE, M. D.

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INDIANA STATE MEDICAL ASSOCIATION
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VOLUME XXVI AUGUST, 1933 NUMBER 8

ORIGINAL ARTICLES

SPINAL ANESTHESIA*
(CAUSES OF SUCCESS AND FAILURE)

CLARENCE S. BAKER, M. D.
EVANSVILLE

During the past few years spinal anesthesia has been a subject of renewed interest and discussion. Its use has become so general that practically all surgeons and anesthetists have had some degree of experience with it, and various reports of successes and failures have been made. Many methods of administration and dosage of different agents and their combinations have been advocated for successful anesthesia, with due regard for comfort and safety to patients undergoing surgery.

After a long period of development spinal anesthesia is today accepted and generally considered as a valuable addition to the armamentarium of every surgeon and anesthetist. To reach this point of acceptance, there must be a great achievement of merit in the advantages offered by use of this method of anesthesia. The truth of this statement must be admitted by all open-minded persons, regardless of whether or not they are advocates of its use. Many criticisms have been broadcast by the laity and by members of the medical profession who have never seen its use and know nothing of it, and by others who have seen its use by improper technique, with poor results, and have gained incorrect impressions. Through the years of its developmental period it has had to overcome many disappointments and impediments in order to arrive at its present state of safety and practicability.

The advantages have often been enumerated, but a brief mention of a few will not be amiss here:

(1) Many persons who have previously undergone surgery with inhalation anesthesia remember the disagreeable sensation of loss and return of consciousness, and hesitate to submit to a second or third experience, even though an operation is imperative. They dread the anesthetic more than the operation. To these patients, a correct presentation of the ease with which subarachnoid block may be administered, and the comfort and satisfaction which may, by proper technique, be obtained during and after operation, as compared to any other method, usually quiets their fears and gains their consent.

(2) Correct spinal anesthesia is an aid to better surgery because of more complete relaxation, which permits better exposure with less trauma. Fewer deaths result as post-operative complications are lessened. As skill in its use increases, appreciation of its advantages and adaptability grows.

(3) Before operation, fluids and food may be given nearer to time of operation, or, if an emergency, the operation may be performed regardless of food having been taken.

(4) During operation, the patient may be conscious and clear in mind, or somnolent from premedication, if thought best because of temperament. This makes possible a closer observation of his general condition. The anesthesia is nearer perfect than with any other method. In most cases packs and pads are not necessary as intestines drop away from the site of operation. The operation may be, and usually is, done quicker and easier, and with less damage to tissues.

(5) Post-operative shock is less, since nerve fibers carrying impulses from the operative field toward the brain are blocked. Since metabolic disturbances are greatly lessened, there is less danger of severe reactions which often follow prolonged deep inhalation anesthesia. Normal functions of kidneys, liver, and intestines are less disturbed during the period of anesthesia. Depression of circulatory and respiratory systems is less. Violent and lasting nausea and vomiting, with gastric and intestinal distention and various forms of restlessness, which often follow inhalation anesthesia, are usually absent. Patients may take food and drink sooner following operations.

DISADVANTAGES

(1) When anesthesia is induced by any method or drug, there may be criticism against either the method, drug, or technique employed. This is also true of spinal anesthesia. It is not a method of

* Presented before the annual session of the Indiana State Medical Association at Michigan City, September, 1933.

universal application and can never be so. It should be only in the hands of those who have made a special study of its principles of technique and dosage, and have gained skill by experience in its use. Its success, in hands unaccustomed to its use, cannot be compared to that of ether, which works better if administered properly, we admit, but may be given in three times its proper dosage (and often is) yet the patient still lives. Abuses of spinal anesthesia by improper technique and dosage are common, and are responsible for all objections to its use today. If spinal anesthesia is dangerous, it is because it is used carelessly, without proper consideration of the importance and necessity for exact dosage of agents necessary for the operation in hand; and without recourse to safe drugs and protective measures; if it is ineffective, it is because the technique has not been perfected. As we look back over our early experiences, we realize that our poor results need not have occurred.

(2) There is a limit to the duration of spinal anesthesia, dependent upon the drug used, the dosage, the quantity of fluid used for expansion, position of patient, etc. By a common method, which should now be obsolete, viz., the use of one drug, one dose, one position, and one quantity of fluid for expansion in every case, many operations will last longer than the duration of the nerve block. This constitutes a failure which may be posted against spinal anesthesia, but which should usually register against the technique instead. We have had perfect anesthesia for many operations lasting two to two and one-half hours.

(3) Among other disadvantages which have been enumerated is occurrence of palsies, headaches, etc., which do not occur often enough to consider; at least, we haven't seen them. In a series of 1,000 cases I have seen no palsies and but one headache, which was thought to be a result of the anesthetic. Headaches have been known to occur following ether anesthesia. Rest assured, if anything occurs to disturb the comfort or well-being of a patient following spinal anesthesia, some relative, friend, or perhaps a physician unfriendly to the method, will place the blame there at once, but if spinal anesthesia has not been employed, no blame is lodged against any other anesthetic. Therefore, in the interest of a useful and necessary form of anesthesia, we should select good risks, as well as bad ones, in justice to its use. When moribund cases are accepted, it should be understood that there is danger with any anesthetic.

Indications

This method of anesthesia can be used safely and effectively for all surgery below the diaphragm, and its use is possible for many operations higher in the chest, neck, and even head.

(1) It is especially indicated where inhalation anesthesia is dangerous, but should not be unjustly censored should results be bad when employed in cases where inhalation anesthesia would certainly be fatal and operation a last chance.

(2) In aged, debilitated patients, with heart, kidney, liver, or lung diseases, the anesthetic is usually perfect without any sign of danger.

(3) Cases with high blood pressure may be safely submitted to spinal anesthesia, and, with proper precautions, undue alarm need not be felt. Low blood pressure has been generally accepted as a definite contraindication, but since the introduction of ephedrin, and methods of controlling the diffusion of novocain, spinal anesthesia is no longer contraindicated in hypotension. Other specific indications include diabetes, pneumonia, pulmonary tuberculosis, and eclampsia.

(4) Electrical apparatus may be used without danger of explosion.

(5) Complications are reduced; as consciousness is preserved, there is no danger of aspirating mucus into the trachea or bronchi.

(6) Postoperative hernia is less frequent.

(7) From the patient's standpoint, spinal anesthesia is more pleasant than inhalation anesthesia, as the induction period is smooth and short, and without any feeling of suffocation or disagreeable odor.

(8) Children are good patients for spinal anesthesia, as the induction is painless. When the spinal tap is done properly, they needn't know any operative procedure is contemplated, and the first knowledge of the operation is obtained after sensation returns in bed.

(9) Such operations as prostatectomy, amputations, herniotomies, Caesarian section, are all best done under spinal anesthesia. If this is the best anesthesia for bad surgical risks and difficult operations, why not best for all others?

Records

A card record system, listing every case operated with spinal anesthesia, has been kept and has given to me more information and satisfaction concerning its use than all the text books and articles published. The card lists the name, residence, age, height, and weight of the patient; name of the surgeon; operation performed; premedication, if any; time required for completion of the operation; drugs, or combination of drugs used, and amount of each; site of spinal tap; amount of fluid drawn for expansion, if any; position of patient, at first and after desired anesthesia is obtained. Height of anesthesia, and time required for it to reach the desired height, is noted. Condition of patient throughout operating time, as to color, pulse, and respiration; nausea or not; attitude of patient —cheerful and comfortable—or suspicious and depressed; and any other data, which I would care to remember, may be recorded. Every case, which is especially gratifying to the patient and surgeon, is carefully recorded and the same technique repeated in like patients for like operations. Likewise, every case which may not be perfect is re-

ferred to and the mistake in dosage or technique noted, so that in a similar case the cause of error may be avoided and the next one made perfect.

I regard the science and practice of spinal anesthesia a field which furnishes food for thought, and its success can be attained only by constant, intelligent practice. Every case for spinal anesthesia is a law unto itself, in that the patient, the operation proposed, and also the ability of the surgeon, must be thoughtfully considered by the anesthetist, for a proper calculation of dosage and technique to make it a successful anesthesia. The anesthetist who administers the same single agent, in the same dosage, in the same way to every patient, for every operation, cannot do successful spinal anesthesia which will promote the method instead of hinder it.

Our experience in spinal anesthesia has been during the past two and one-half years. We have anesthetized 1,000 patients for surgery. The ages have ranged from five years to eighty-eight years; the weight from 50 pounds to 310 pounds. The greater number have been good surgical risks. Many have been bad risks, some extremely bad and were last-chance operations. The dosage has ranged from .05 gm. (50 mgm.) of novocaine to .70 gm. (700 mgm.) or its equivalent by mixtures with spinocaine or nupercaine.

No deaths have been attributed directly to the anesthetic. Only one death has occurred on the table, and that was in a moribund case with intestinal obstruction. The patient was unconscious before admission to the hospital. Operation was a last-chance attempt, and death was expected, with or without an anesthetic. For the sake of spinal anesthesia, it should not have been done, but the result would certainly have been the same under ether.

My experience thus far in spinal anesthesia has convinced me that the Trendelenburg position, soon after the introduction of novocaine or neocaine into the dural sac, is the most common error in technique, and regardless of the wide prevalence of its use, it is a mistake, and the source of most disagreeable experiences which have been reported. Dyspnea, pallor, drop in blood pressure, collapse, etc., may follow administration of small doses: .10 gm., .12 gm., .15 gm., especially if large amounts of fluid are drawn and barbotage practiced. Twice the dosage may be used without these symptoms, if the head and shoulders are raised, and a small amount of fluid used for expansion, with slow injection into the dural sac.

As proof of my statements, I quote a few reports. First, from an article which appeared in *The American Journal of Surgery*, March, 1931, as follows: "Within a period of three months, there were three fatalities from spinal anesthesia. These all occurred on the table, before the operation was begun. These were definitely and without a question of doubt caused by the anesthetic. These patients were apparently all in good physical condition and had been in the hospital from five days to two weeks before operation; they were all considered good surgical risks. Two of these cases were gynecological; the third was a secondary operation on an old empyema. They all received 200 mg. of novocaine in 10 c. c. of spinal fluid reinjected by barbotage at about the level of the second lumbar space in the lateral prone position. They were all immediately placed in the Trendelenburg position and all complained at first of an inability to breathe and speak. Apparently these patients all died of a respiratory failure; they were unable to breathe, they could not inhale. The pulse was obtainable at the wrist and over the heart for fully fifteen minutes after respiration had apparently ceased. During this time the patients made repeated efforts to breathe but were unable to do so. Whether this was due to a failure of the respiratory center or to a failure of the respiratory muscles one cannot definitely say. The impression obtained at the time was that death was due to a failure of the respiratory muscles. The central stimulus seemed to be present and acting. Apparently the nerves to the muscles were anesthetized and the muscles became paralyzed. In one case, second gynecological, an attempt was made to maintain respiration with the respirator but this failed. This was apparently due to the fact that the patient had to be transported to another part of the hospital and the respirations were suspended too long for resuscitation to occur."

COMMENT

In these cases quoted, .20 gm. (200 mgm.) of novocain dissolved in 10 c. c. of fluid and barbotage practiced, probably increased fluid expansion to near 20 c. c. Then immediate Trendelenburg position caused gravitation of the anesthetic solution upward before the lumbar nerve roots had a chance to absorb it. The result was anesthesia of the head and neck, instead of the abdomen, where needed, paralysis of respiration, and death, which would not have occurred if the anesthetic solution had been allowed to saturate the lumbar nerve roots and arise slowly to the desired height by diffusion.

In my opinion, these were unnecessary deaths and would not have occurred with twice the dosage given, had the technique been changed to this: two c. c. of fluid drawn instead of 10 c. c., and replaced slowly without barbotage, slight Fowler position for the first twenty or thirty minutes until novocaine solution was fixed in the nerve roots, then level on table and in bed with pillow under head. No dyspnea, color good, pulse good, anesthesia good, nothing even to suggest cause for alarm should result.

Another quotation from an article on "*One Thousand Cases Without a Death*," the *Medical Journal and Record*, June, 1932; under "Technique," the article reads: "Our patients are all placed in a recumbent position and the head of the table lowered enough to raise the pelvis above the level of the patient's head."

CASE I (Hospital Number 5734) — A female patient, forty-two years of age, apparently a good surgical risk, blood pressure 140/80, pulse 80, was anesthetized spinally for operation upon the gallbladder. Neocaine 0.12 gm. was injected into the first lumbar space. Immediately after making the abdominal incision, the patient became rigid, had facial twitchings, blood pressure was lost, peripheral pulse was absent, respiration was slow and shallow, and cyanosis rapidly developed. Palpation of the heart through the diaphragm revealed weak and slow contractions. Within three minutes of the onset of these signs and symptoms intravenous glucose was begun. However, at the first danger signal, all the other resuscitating measures had been operating effectively; respiratory stimulation including CO_2 and oxygen, high Trendelenburg position, etc. Soon thereafter the patient rallied from this state, cardiac contractions were more forcible, cyanosis disappeared, the radial pulse was becoming perceptible, and the patient could be roused. Sufficient improvement was observed to permit the required surgical procedure, and the patient made an uneventful recovery from a cholecystectomy operation.

CASE II (Hospital Number 6487) — A female patient, fifty-two years of age, blood pressure 138/80, pulse 96, received 0.12 gm. neocaine for spinal anesthesia, by injection into the first lumbar space. Her pressure steadily dropped and just as the peritoneal cavity was being entered, no pressure could be recorded. Respirations were hardly noticeable and practically ceased, the patient became quiet and stuporous, and there was a marked pallor. Peripheral arterial pulsations were not elicited, and blood pressures were not obtained. A fatality seemed imminent and unavoidable. Thereupon the usual emergency measures were given: rhythmic compression of the thorax, intravenous glucose, carbon dioxide and oxygen, increased Trendelenburg position, and cardiac massage. The patient slowly responded to such a degree that cholecystectomy was safely accomplished. There was no further discomfort to the patient, and a calm, unperturbed convalescence resulted.

CASE III (Hospital Number 4978)—A female patient, sixty-six years of age, considered a fairly good surgical risk, blood pressure 140/80, pulse 120, was operated upon for cholecystitis and cholelithiasis. Anesthesia was soon complete after the injection into the second lumbar space of 0.12 gm. neocaine. Upon incising the abdominal wall the patient suddenly became stuporous, and radial pulse and blood pressure readings were not obtainable. Immediate palpitation of the heart through the diaphragm elicited no cardiac pulsation. The exposed tissues assumed a cadaverous appearance, and bleeding and venous oozing was entirely absent. The usual emergency measures were immediately instituted, saline being used on this occasion for intravenous infusion. The first change noted was more forceful cardiac contractions although the heart rate was still slow. Peripheral vessels in the subcutaneous tissues started bleeding, skin and mucous membranes became pink and then reddened, and the patient acted as if roused from a sound sleep. Recovery was sufficient and considered safe enough to perform a cholecystectomy.

COMMENT

These patients were saved by emergency measures, but why should the conditions described have occurred? With this small dose 0.12 gm. (120 mgm.) *without* Trendelenburg position, the anesthesia would never be high enough for surgery in the abdomen, and *with* Trendelenburg, the duration of anesthesia is not sufficient for the average surgeon, especially in a difficult operation. Three times this amount of novocaine, or neocaine, for cholecystectomy, with small expansion and slight Fowler position, would have given better anesthesia for a much longer time, with safety to the patients who were described as good surgical risks.

The theory of splanchnic dilatation and cerebral anemia, with falling blood pressure, and its correction by Trendelenburg position sounds good. However, in my practice of spinal anesthesia it does not prove out, as the only cases which I have known or observed, in which the alarming symptoms of pallor, dyspnoea, falling blood pressure, etc., have occurred following small doses for lumbar block, the patient was in immediate Trendelenburg position. The chief factor in such instances is the presence of a too concentrated solution of the drug in the upper spinal canal, due largely to faulty position. When this position is necessary for a type of operation such as pelvic laparotomy, a solution lighter than spinal fluid makes it safe, or after a sufficient time has elapsed for the heavy solution to be absorbed by the lumbar nerve roots, and diffusion has reached its height, *then* Trendelenburg is safe.

Unfortunately, the popularity of spinal anesthesia has led to its widespread use by men not familiar with its physiology and little versed in its technique. The usual method is done according to the idea that a small dose, with patient in Trendelenburg position, is efficient and safe. This is far from the truth and results in unsatisfactory anesthesia, with complaints from patients, and resorts made to inhalation anesthesia for completion of the operations, not to speak of the unpleasant experiences referred to in reports quoted in this paper.

All this leaves an incorrect impression and hinders rather than promotes a good and useful method of anesthesia. In my opinion it is a great mistake to encourage the wholesale use of subarachnoid block, because the method is bound to pass into the hands of the less experienced and become a potential menace. If the anesthetist or surgeon is willing to make sufficient study, and can by intelligent practice and observation develop a technique which makes it a safe and efficient method, he will have the satisfaction of rendering

a real service for good in the fields of anesthesia and surgery.

DISCUSSION

H. C. Ragsdale, M. D., Bedford: The question of spinal anesthesia, the same as with any other method of procedure in medicine, brings forth an avalanche of criticism, coupled with various and diverse ideas as to technique, indications, etc., which in all are confusing to the average physician and surgeon. One must learn to separate the wheat from the chaff, resulting in an effective and safe technique, based upon practical experience and effect rather than upon animal experimentation and the test tube.

Until a better working theory is found I shall continue to accept this one: That the effect of spinal anesthesia is to produce an extensive regional nerve block and not a transverse paralysis of the spinal cord. The anesthetic agent produces a blocking of the posterior and anterior nerve roots, along with the associated rami communicantes. There results a loss of smooth and skeletal muscle tone and a decrease in peripheral resistance to blood flow by vasomotor nerve paralysis, with an accumulation of blood in the vessels of the anesthetized area. We have now a fall in blood pressure. If this drop is extreme there may be an inadequate supply of blood reaching the vital cerebral and medullary centers, with a resulting anemia of the brain. It is important, then, that the brain and heart receive an adequate supply of blood to maintain vital function. By using the Trendelenburg position the force of gravity plays an important part in keeping the brain supplied with necessary blood. In my opinion the Trendelenburg position should always be used after the injection is made, and I believe this position should be maintained for at least four hours after the patient is returned to his room, even to the extent of maintaining this position on the stretcher while he is being transferred from the operating room to his own bed. The position should be such that a horizontal line drawn from the anterior superior spine of the ilium will completely cover the forehead. In following this method of lowering the head I have never seen anesthesia of the head existing where there should have been anesthesia of the abdomen and extremities.

The height of the anesthetic and the rapidity with which solutions of procaine unite with the nerve lipoids is a fairly constant one and depends upon the amount of drug used, the amount of fluid reinjected, the force with which it is injected, the use of barbotage and the selection of the proper interspace for injection.

Large quantities of anesthetic agent dissolved in large quantities of spinal fluid and injected with considerable force are bound to cause a collapse, with dire results insofar as the patient is concerned.

The use of ephedrine is still a moot question, some claiming that it does more harm than good. I believe that if properly used it assists in sustaining the blood pressure.

The question of preanesthetic narcotics and sedatives has not been discussed. I believe that the barbituric derivatives should not be used, as they cause a respiratory depression and a lowered resistance of the medullary centers to the paralyzing effects of procaine.

The hostile attitude of some of our most prominent surgeons concerning the use of this agent is to be deplored. Many of them have had little or no experience in its use and are opposed to it through hearsay. Their influence is very detrimental in that they cause their own patients and their professional clientele to become antagonistic to its use. Because of this, certain communities are prejudiced against spinal anesthesia so that it can seldom be used.

Spinal anesthesia is here to stay. It will be used by all classes of surgeons, good, bad and indifferent, and the simpler we make the technic the lower will be the mortality rate and the better the name for spinal anesthesia.

Dean Lewis, M. D., Baltimore: I would like to say that spinal anesthesia has a definite place and in some instances has a decided advantage over general anesthesia. If employed by those who know the indications and contraindications and the technique of administration, it is good; if employed by those who do not understand its use, it is bad. In these particulars spinal differs in no way from general anesthesia. It should not be used as a routine. I use it a great deal when amputations are to be done in old people. It is useful in many lesions in which any other type of anesthesia would be distinctly harmful. I have seen patients suffer acute mental auguish under spinal anesthesia, and for this reason a general anesthetic is preferable in many cases.

We use almost every anesthetic, according to indications. In some bad risks ethylene is used in spite of the explosions which have occurred. Avertin has many advantages. It has distinct advantages in exophthalmic goiter, for the patient may be put to sleep in bed and remain asleep for some time after the operation. In this way the excitement attendant upon going to the operating room is avoided. In brain surgery it is one of the best anesthetics. As the result of its use, the bulging brain is obviated.

We should not use any anesthetic routinely; each should be selected to suit the case. I am sure that the institution which has the best anesthetists will secure the best results and will employ the anesthetic particularly suited to the case in hand.

Don F. Cameron, M. D., Fort Wayne: This paper and Dr. Ragsdale's discussion bring up one feature of spinal anesthesia which I believe needs

especial emphasis in order to avoid serious accidents. This relates to the time at which the Trendelenburg position is permissible after the spinal injection. This warning is necessary because very many doctors have received circulars purporting to give the Labat technique, in which it is stated that an immediate Trendelenburg position is necessary even after the injection of heavy solutions, as neocaine and spinal fluid. There is no doubt in my mind that placing all patients in the Trendelenburg position immediately following the injection of a heavy solution of procaine is a very dangerous procedure. It is frequently followed by a fall in blood pressure and a general collapse of the patient.

During the past year I have been using spinal anesthesia with increasing frequency and satisfaction, but with the following modification of technique. A heavy solution of not over 150 mg. of procaine is used, the injection is made with the patient sitting up, and this position is maintained for one to two minutes after the injection. He is then placed in a horizontal position with the head on a pillow and is never allowed in the Trendelenburg position unless the operation requires it, and then not until at least twenty-five minutes have elapsed since the injection. The warning should be frequently repeated: no Trendelenburg position immediately after the injection of a heavy solution.

CLARENCE BAKER, M. D., closing: As to the literature distributed concerning the Labat technique, I think that is the reason why so many men use small doses and place patients in the Trendelenburg position. I made my grounds clear on that, and I made the statement that I felt sure it is a mistake. The Pitkin solution (spinocaine) is lighter than spinal fluid, and for that reason you must use the Trendelenburg position when using it. After a sufficient time has elapsed to permit the nerve roots to absorb the anesthetic fluid, the Trendelenburg position is all right with heavy solution. I do not think it makes much difference how long it is maintained after the patient is back in bed, but immediately after the injection, if you keep the patient's shoulders slightly raised so that they are higher than the pelvis, it will be safe and there will not be any respiratory embarrassment. If you try this out on a sufficient number of patients you will note the difference.

I administer spinal anesthesia for so many different surgeons that if I had followed Labat's advice I would have had to quit using this method of anesthesia long ago. With 100 mgs. and immediate Trendelenburg position there is often respiratory embarrassment. With the larger doses of novocaine and with the shoulders up for a time you are safer than when using small doses with the shoulders down.

Some surgeons do operations in one-half the time required by others, and this is one of the factors that must be taken into consideration. If you can do an operation in forty-five minutes, that patient does not need an anesthetic that will last an hour and a half; but for the slow operators I anesthetize the patient so that the effect will last. If we have to use an inhalation anesthetic to finish the operation it leaves a bad impression, for the spinal anesthestic is used to avoid this. Patients can be anesthetized so that the effect will last for an hour and a half or two hours, but you cannot do this and put them in the Trendelenburg position immediately. You may use novocaine in combination with nupercaine that will last for an hour and during that time the nupercaine has been getting in its work and will last for another hour, and the patient will be in good condition.

DIARRHEA IN INFANCY AND CHILDHOOD

TREATMENT WITH THE MORO APPLE DIET

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The old adage, "An apple a day keeps the doctor away," seems to be true in more ways than one, and the anti-constipationists may be surprised to learn that the apple can be used for just the opposite condition than that for which so many of us have advised its use.

Professor Moro, of the University of Heidelberg, has devised a method of treating those troublesome diarrheas of childhood and infancy, a treatment that is used by many of the clinicians of Europe, especially by Hamburger of Vienna, Czerny and Finkelstein of Berlin, and, of course, by Moro at Heidelberg. Ochsenius, Kleinschmidt, and Fanconi use it in a modified form. Many of the cases of diarrhea coming at the time of the year that they do, it seems that nature has kindly provided us with one of the simplest of remedies, one that is easily obtained during the late summer and early fall months. The utilization of apples for the treatment of diarrhea seems to be an entirely novel use for this ubiquitous fruit, although some of us may remember of having our mothers or grandmothers scraping an apple and feeding it to us, way back when we were children and had "stomach trouble" or "bowel trouble."

In this report no attempt will be made to explain the chemistry and physiology involved. If the results are worthy of recognition, interest may be aroused in someone who has the facilities of research to inquire into the underlying causes and put this method on a rational basis. Except for a modification of the use of drugs the method described is that of Moro.

Ripe, freshly grated or scraped raw apples are used. The variety of apple seems to make no difference, although when more is learned one type may have an advantage over another. The apples should not be over-ripe, and none of the seeds, skin,

or core are used. The apples are prepared only as used, as by standing and becoming brown they would tend to have the same effect as cider. It is very important that they be used immediately after preparation.

Twelve cases of diarrhea treated with the apple diet are reported. The diarrheas were due to various causes. The ages ranged from six months to nine years. Four cases were the usual "summer diarrhea" type. In three cases the diarrhea followed upper respiratory infections, and two were convalescent measles cases. One case was that of an eighteen-months-old baby with furunculosis, and another, a girl, age four years, had diarrhea following a dietary indiscretion. These cases then cover enteral as well as parenteral types of diarrhea.

CASE REPORTS

1. N. H., female, aged three years. Diagnosis, gastro-enteritis. No elevation in temperature. Duration of diarrhea, twenty-four hours; no vomiting. Preliminary treatment consisted of twelve-hour fast. Number of stools before treatment, eight, light yellow, daily. Medication, ten grains of calcium carbonate, three times daily. Result: diarrhea stopped after twelve hours of taking apples.

2. J. W., male, aged eight months. Diagnosis, upper respiratory for two weeks. Rectal temperature, 101. Duration of diarrhea, one week; vomiting, one week; eight to ten green, watery stools, daily. Preliminary treatment, twelve-hour fast. Medication, calcium carbonate, grains ten, and phenobarbital, grains one-fourth, three times daily. Result: first bowel movement, twenty-four hours after beginning apples; mild attacks of diarrhea subsequently controlled by giving one grated apple daily with regular diet.

3. J. S., female, aged fourteen months. Diagnosis, gastro-enteritis; feeding problems; teething. Rectal temperature, 100. Duration of diarrhea, one month; no vomiting; seven or eight green-brown, slimy stools with mucus, daily. No preliminary treatment given. Medication, calcium carbonate, grains ten, three times daily. Result: diarrhea stopped by end of fourth day.

4. M. S., female, aged nine months (seven month; premature). Diagnosis, "summer diarrhea" and teething. Rectal temperature, 100. Duration of diarrhea, twelve days; no vomiting; five watery, green stools with mucus, daily. Medication, calcium carbonate, grains ten, and phenobarbital, grains one-fourth, three times daily. Result: diarrhea stopped at conclusion of treatments; recurrence in three weeks.

5. R. P., male, aged six months. Diagnosis, gastro-enteritis. Rectal temperature, 98.6. Duration of diarrhea, two days, with vomiting; watery, green, slimy stools every two or three hours. Preliminary treatment, eight-hour fast. Medication, calcium carbonate, grains ten, three times daily. Result: stools soft and brown after twelve hours of apple diet.

6. K. L., male, aged seven months. Diagnosis, upper respiratory. Rectal temperature, 99.6. Duration of diarrhea, three days; vomiting at onset; green, watery stools, eight in last four hours before physician was called. Preliminary treatment, eight-hour fast. Medication, calcium carbonate, grains ten, and phenobarbital, grains one-fourth, three times daily. Result: mother was to return if baby did not improve; did not return. Communication later indicated that diarrhea stopped.

7. V. K., female, aged four years. Diagnosis, feeding indiscretion. Temperature, by mouth, 101. Duration of diarrhea, two days; no vomiting; five green, watery stools daily; blood second day. Medication, phenobarbital, grains one-fourth, three times daily. Result: diarrhea stopped within twenty-four hours.

8. S. K., female, aged twenty-two months. Diagnosis, post-measles. Rectal temperature, 100. Duration of diarrhea, six days; no vomiting; frequent, bloody mucus stools. Medication, calcium carbonate, grains five, three times daily. Result: only two bowel movements on following day, with no recurrence.

9. E. K., female, aged five years. Diagnosis, post-measles. Rectal temperature, 99.6. Duration of diarrhea, five days; no vomiting; frequent blood, mucus stools every one to two hours. Medication, calcium carbonate, grains five; three times daily. Result: no bowel movement the following day.

10. J. H., female, aged eight months. Diagnosis, furunculosis. Temperature, rectal, 99.6. Duration of diarrhea, two days; no vomiting; green, watery stools every one to two hours. Medication, calcium carbonate, grains ten, phenobarbital, grains one-fourth, three times daily. Result: stools soft, brown, with no diarrhea on following day.

11. H. D., male, aged three and one-half years. Diagnosis, upper respiratory. Rectal temperature, 100. Duration of diarrhea, two days; vomiting, two days; brown, watery stools every three to four hours. Preliminary treatment, six-hour fast. Medication, calcium carbonate, grains twenty, and phenobarbital, grains one-fourth, three times daily. Result: stools normal on following day.

12. C. A., male, aged nine years. Diagnosis, tonsillitis, pharyngitis and ileocolitis. Temperature, by mouth, 100.5. Duration of diarrhea, two days; no vomiting; thirty-two green-brown watery stools in previous forty-eight hours. Medication, calcium carbonate, grains ten, three times daily; aspirin for fever; gargles. Results: no bowel movement on following day.

COMMENTS

A group of only twelve cases is insufficient for the proof of any form of treatment, but the fact that the apple diet was tried in only these twelve cases, and was successful every time, would indicate that there is some justification for the belief that there is value to this regime.

György,[5] of Heidelberg, attributes the success of this form of treatment to the following:

1. Child's appetite is satisfied; fluids are supplied and the child does not feel hungry.
2. Apples are easily absorbed.
3. Tannic acid in the apples is of value.
4. The pectins may be the most valuable factor.

McLester states that the apple has definite laxative properties, probably due to the large cellulose content. Small amounts of vitamins A, B and C are present. The young apple contains mostly starch but as the apple ripens this is converted to almost entirely carbohydrate. Pectin, valuable in jelly formation, decreases with the ripening of the fruit.[6] There is a possibility that the pectin is the important element involved and it would be interesting to see what results might be obtained with the use of a preparation of this substance.

Tannic acid has long been used as an intestinal astringent. Tea also furnishes a source of tannic acid; however, it seems that equally good results are obtained when plain water, Ringer's, or Hartmann's solution is used.

Treatment of Less Severe Cases

First and second days: 100 to 200 grams of grated raw apples are given four to five times a day. There seems to be no danger in giving too much. I have seen a five-year-old girl take two to three pounds of apples a day. Within eighteen to twenty-four hours the stools will change from their diarrheal character to brown color, soft and smooth in consistency. One day is usually sufficient, although in severe cases it may be necessary to use the apples for two days. As other foods are added, the apples are continued in descending amounts. Calcium carbonate grains five to ten, and phenobarbital grains one-fourth to one-half, three times daily, are given throughout the first week of treatment. With infants and older children the calcium carbonate may be mixed with the apples. If necessary, saccharine may be added to sweeten, although I have never found this required.

Third day: Add cottage cheese (the calcium carbonate may be mixed with the cheese), zweiback or dry toast, oatmeal gruel with one egg-white, and tea.

Fourth day: Add two egg yolks and some mashed potatoes.

Fifth day: Add butter.

Sixth day: Add meat.

No milk all week. Skimmed milk may be used on the fifth or sixth days in the mild cases.

Severe Intoxication with Vomiting

The vomiting can usually be controlled in a few hours by divided small doses of atropine and codeine. Tea or Ringer's solution is given by mouth for eight to twenty-four hours, depending on the severity of the intoxication and dehydration. (Hartmann's solution may be given if desired.)

After the tea pause (the following amounts are totals for twenty-four hours).

Age 2 Months.

200 grams grated apples.
500 c. c. Tea or Ringer's solution.

Age 3 Months.

300 grams grated apples.
700 c. c. Tea or Ringer's solution.

Age 1 Year.

250-300 grams grated apples three to four times a day, with Tea or Ringer's solution.

If the intoxication is not marked, the amount of fluid may be reduced and the apples may be increased. Of course each case must be treated individually and the subsequent feeding modified to fit the circumstances.

After eighteen to twenty-four hours the stools improve and the food may be started in the form of breast-milk, diluted skimmed milk or buttermilk. Calcium carbonate and phenobarbital are used in infants as well as in older children. These two drugs can be powdered and mixed with the apples or cottage cheese.

Children, and infants as well, take the apple without trouble, in fact usually are quite greedy.

Comment

Ochsenius[1] feels that further experience is necessary before he would advise the adoption of this form of treatment.

Kleinschmidt[2] mentions the use of ripe bananas and raw fruit juices; also stressing the point that in the apple diet the transition through the not easily digested carbohydrates must be gradual, and the return to milk must be slow.

Fruit juices (orange and huckleberry) or 200 to 500 grams of sieved ripe bananas are used for the first two days by Fanconi, of the University Children's Clinic of Zurich. He states that grated raw apples are also good but feels that the results are not as good as with bananas, or a combination of the two. When the diet was first instituted relapses were common. It has been recently discovered that this was due to a too liberal supply of carbohydrate and a too rapid addition of milk.[3] Whole milk should be withheld until late in the convalescence.

G. Popoviciu[4] reports good results with the Moro apple diet, especially in parenteral diarrhea. He reports two cases in detail, one of broncho-pneumonia and one of marasmus. He believes this simple method of treating the grave parenteral diarrheas of considerable importance.

In the twelve cases reported, all except one responded to treatment within twenty-four hours. The exception was a baby (case three) of fourteen months who had had a diarrhea for four months. In this case the diarrhea was checked at the end of four days. To date this treatment has been tried in only one adult and failure resulted be-

cause the patient disliked apples and refused to eat them.

It appears that this European method of treatment has a distinct value and merits further trial.

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MEDICAL EMERGENCIES IN PEDIATRIC PRACTICE*

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In practice we occasionally meet with medical conditions, the outcome of which depends on prompt recognition and proper treatment. Apparent didacticism in this paper is in the interest of brevity.

In the neonatal period, asphyxia, hemorrhagic disease of the new-born, and intracranial hemorrhage deserve attention.

ASPHYXIA

Yandell Henderson[1] states that many new-born infants die who could and should live. Asphyxia may occur from mechanical causes before, during, or after labor; immaturity of the respiratory mechanism; or from use of analgesics or anesthetics. The following outline of treatment is suggested by Bonar[2]:

1. All measures of violent nature should be avoided, including spanking, contrast baths, swinging between the legs, and vigorous artificial respiration, which may increase an already existent cerebral ischaemia.[3]

2. Absolute warmth, rest, and quiet should be supplied.

3. Air passages should be cleared immediately. As soon as the baby is born any debris is removed from the mouth and nares by an ordinary ear bulb. Before the cord is cut the infant is suspended by the feet and the trachea and larynx gently milked toward the mouth, followed by bulb aspiration again.[4] Mathieu and Holman[5] advocate aspiration of the trachea with a catheter attached to a glass trap.

4. Administration of oxygen with 5 to 10 per cent CO_2, preferably with a specially devised infant inhalator such as the McKesson. O_2 supplies food to the respiratory center and CO_2 acts as a stimulant. In the absence of such apparatus the CO_2 may be supplied by gently puffing about forty times a minute through the tracheal catheter. The reflex tone of glottis felt in passing the catheter is the best index of viability. If active, the infant will respond to CO_2. If response is absent, he usually is dying.

Gentle mouth to mouth insufflation may, through necessity, effectively be substituted for one of these methods.

INTRA-CRANIAL HEMORRHAGE

Postmortem reports show that 30 to 60 per cent of neonatal deaths are due to intra-cranial hemorrhage, the result of trauma, or hemorrhagic diathesis. Failure to respond to CO_2 stimulation and cyanotic attacks often furnish the first clue. In a massive type of hemorrhage, the baby is restless, cries excessively at first, followed by feebleness of cry, lethargy, tremors of arms and legs, or convulsions. Eye signs are nystagmus, strabismus, or irregular pupils. The sucking reflex is absent. If the hemorrhage is over the vertex, the fontanelle is bulging. A torn vein entering the longitudinal sinus, a rupture of the tentorium or damage to the choroid plexus, with resultant intraventricular hemorrhage, are the usual mechanical causes.

Treatment consists of:

1. Performing a cisternal or spinal puncture, repeatedly if necessary. Some authorities, however, claim that release of pressure by drainage promotes further bleeding.

2. Giving 30 to 50 c. c. of whole blood intramuscularly. In many clinics, including our own, this measure is used as a routine prophylactic measure as soon after birth as possible.

3. Maintaining the baby in a state as absolutely quiet as possible, with the use of sedatives if necessary. Riesenfeld[6] advocates placing the baby in an almost vertical position. In this position pressure within the cranial veins is lessened.

HEMORRHAGIC DISEASE OF THE NEW-BORN

Hemorrhagic disease of the new-born, which occurs during the first three days, is manifested by hemorrhages into the skin, from the mucous membranes, and umbilicus. It is a transient, though severe, reaction of the new-born to chemical injury of the reticulo-endothelial system. Clotting time is prolonged.

Bleeding, which occurs later, second or third week, is usually due to syphilis or sepsis.

Treatment consists of the intramuscular or intravenous transfusion, into the longitudinal sinus or jugular vein, three c. c. per pound of whole blood, usually from a parent. Repeat in four to twenty-four hours if bleeding continues.

Kugelmass[7] advocates prenatal high protein diet for the mother and the feeding of 3 per cent gelatin every two hours to the new-born as prophylactic measures.

INTESTINAL INTOXICATION

Acute nutritional disturbances are at times of emergency nature, especially so-called acute intestinal intoxication (toxicosis), characterized by

* Presented before the annual session of the Indiana State Medical Association at Michigan City, September, 1932.

vomiting, diarrhea, rapid weight loss with dehydration, loss of tissue turgor, a gray ashen pallor, sunken eyes, dry conjunctivae, fever, oliguria, and at times convulsions. According to Finklestein's theory, dehydration results in a disturbance of intermediary protein metabolism in the liver which liberates a "histamine-like" substance that injures the capillaries and causes acute water loss, reduction of blood volume, and intoxication.

Treatment consists of (1) complete gastrointestinal rest; (2) giving of fluids, either glucose preferably by the continuous intravenous drip method of Karelitz,[8] or Hartman's solution, which combats either acidosis or alkalosis. The two fluids may be effectively combined; (3) blood transfusions[9] given early and repeated seem to appreciably decrease the mortality rate; (4) Casparis[10] advises intravenous or intramuscular injection of 2 to 4 c. c. of a 10 per cent solution of calcium gluconate, twice daily, based on the similarity of toxicosis to guanidin poisoning.

Resumption of feeding, preferably with protein milk or lactic acid milk, must be instituted with great caution.

Convulsions

Most of the convulsions in the new-born are due to acute infections or cerebral birth injury; in later infancy they are due to tetany and in childhood to epilepsy.[11]

Tetany, often associated with rickets, may be latent and precipitated by an acute infection. Clinical signs of tetany are Chvostek's sign, Trousseau's sign and carpo-pedal spasm. It occurs most frequently in the winter months. The blood calcium is decreased.

Convulsions may best be immediately controlled by chloroform. As convulsive states are probably due to cerebral congestion or edema, dehydrating measures such as the oral administration of 50 per cent magnesium sulphate—one to two ounces every four hours—is slowly effective; 5 to 10 c. c. of a 25 per cent solution given intramuscularly acts much more rapidly. Active antirachitic therapy, including quartz lamp exposure, should follow. In all convulsive states, except possibly suspected brain tumor, a spinal puncture should be done.

The cerebral manifestations of acute glomerular nephritis[12] are vomiting, headache, visual disturbances, slow heart and respiratory rates, coma and convulsions. There is no retention of nitrogenous end-products denoting uremia. A steadily rising blood-pressure denotes cerebral edema and calls for the administration of magnesium sulphate in doses of 1 to 2 ounces of a 50 per cent solution by mouth or by rectum every four hours. This produces a general dehydration of the tissues including the brain, but does not produce a diarrhea. If coma or convulsions have already occurred, the magnesium sulphate in 25 per cent solution is given intramuscularly in doses of 0.2 c. c. per kilo (2.2 pounds). Fall of blood-pressure and diminution of cerebral symptoms takes place in fifteen to thirty minutes. A second injection can be safely made in two to three hours if there is no response to the first. Several later injections may be necessary, whenever the blood pressure is rising and reaches 140 m. m. of mercury.

Poliomyelitis

In poliomyelitis alert recognition of the preparalytic symptoms is essential. These are prostration out of proportion to the fever, flushed face, anxious expression, mild injection of throat, drowsiness, general hyperesthesia, coarse tremor, slight cervical rigidity and spinal stiffness. Spinal fluid shows positive globulin, increase of cells to between 20 and 250, usually polymorphonuclears at first changing quickly to predominance of lymphocytes.

Convalescent serum to be effective must be introduced before the virus has combined with central nervous tissues. As Draper[13] says, "these are precious moments indeed, for during them the virus is in transit from the systemic circulation to the anterior horn cells and may be intercepted by the neutralizing serum." He advises 50 c. c. of convalescent serum given intravenously or intramuscularly. If the case is seen when the spinal fluid is infected but definite paralysis has not taken place, 15 to 20 c. c. should be given intraspinally as well. The very recent statistical reports of Park[14] and Torian and Winters,[15] however, present rather convincing evidence that convalescent serum may not be as effective as we had hoped it might be. In line with Burrow's[16] conception that poliomyelitis is a very common lymphatic infection of intestinal origin affecting without paralysis a large proportion of the population at some time, the administration of serum from any healthy adult may, if convalescent serum is unattainable, be of therapeutic value.

Meningitis

Without detailing all the symptoms of meningococcus meningitis, I would emphasize the significance of severe headache in a young child, especially if associated with vomiting and cervical rigidity, whether or not the typical rash is present. Varying results in treatment and mortality rate[17] are affected by (1) virulence of the infection; (2) whether endemic or epidemic; (3) whether early or late in the course of an epidemic; (4) quality of serum. One manufacturer's serum may be more effective than another's. Clinical improvement is not always parallel with its agglutination titer.[18] The therapeutic test is the most reliable. Change of serum should be made if prompt clinical and cytological improvement does not take place. The dose of serum is usually 20 to 40 c. c., always less than the amount of fluid withdrawn, every twelve to twenty-four hours until two successive fluids are free from organisms. Return of the sugar content of the spinal fluid to normal is a favorable sign.

The cell count is of little comparative value. Basilar block, more common in infants, may necessitate intraventricular administration of serum, through the open fontanelle.

Obstruction of Larynx

Obstruction of the larynx may be produced by spasm of the glottis, seen commonly in tetany. So called "breath-holding spells" in angry emotionally unstable young children may produce cyanosis but is seldom fatal. Edema of the larynx occurs in urticaria and serum sickness. Acute laryngitis, most common in measles and influenza, may produce marked dyspnea and aphonia.

Diphtheria of the larynx may be primary. Gradually increasing hoarseness, without period of improvement, may go on to aphonia, dyspnea, cyanosis and asphyxia. In malignant or rapidly progressing cases serum should be given intravenously.

Sudden attacks of asphyxia, followed by hoarseness and dyspnea, may be due to aspiration of a foreign body. X-ray is useful in case of doubt.

Retropharyngeal abscess may produce hoarseness, dyspnea and cyanosis and may be mistaken for laryngeal diphtheria.

In all cases of doubt, direct inspection of the larynx should be performed.[19]

Obstruction of Trachea or Bronchi

Obstruction of the trachea or bronchi produces an inspiratory and expiratory stridor, accompanied by use of the accessory muscles of respiration. May be caused by:

1. Diphtheria, usually associated with the laryngeal form.

2. Foreign body, most common in the right main bronchus. It may produce block with resultant absorption of alveolar air and atelectasis. The diaphragm is pulled up; the mediastinum is drawn toward the affected side. Resonance is decreased. Or, it permits ingress of air but not egress with resultant emphysema—increased resonance pushing over of mediastinum to the opposite side and lowering of diaphragm.

Decomposition of the most commonly aspirated foreign body, the peanut, produces the irritating arachidic acid, which stimulates an active inflammatory reaction.

3. Asthmatic bronchitis, usually associated with an acute upper respiratory infection, or hay fever, is manifested by dyspnea and cyanosis. Expiration is prolonged and associated with rhonchi, sibilant, and sonorous rales. Usually there is favorable response to atropine or adrenalin.

4. Obstruction caused by a persistent thymus is probably much more uncommon than we have supposed. Lateral x-ray views showing a crowding of the "critical space of Grawitz" and flattening of the trachea are more important than anteroposterior. It must not be forgotten, however, that the thymus can be physiologically quite large in normal children.

5. Enlarged tuberculous glands may occasionally produce obstruction.

Diabetic Coma

Diabetic coma is manifested by complete stupor, acetone breath, air hunger, dehydration, dry tongue, and soft eye-balls, the presence of sugar, acetone, and diacetic acid in the urine, and high blood sugar. Treatment consists of

1. Keeping the body warm.
2. Enema—gastric lavage.
3. Insulin—40 units intravenously or subcutaneously immediately, 20 to 40 units every three or four hours. Check catheterized urine and blood sugar. Continue insulin until urine is sugar free. When urine is sugar free but acidosis is still present, continue insulin, covering each unit of it with an equal number of grams of glucose. Give fluids, any route, freely.

The two to three days following coma is a critical period chiefly in adjusting the insulin dose to prevent shock.

Poisoning

Poisoning may be due to accident or sensitivity. A complete list is not attempted. Those of chief interest are:

1. *Acids.*
 Antidotes—Magnesia, chalk, milk.
2. *Alkalis.*
 Antidotes—Dilute vinegar, lemon juice, egg white.
3. *Analine Dyes*, especially shoe dyes, which produce cyanosis, drowsiness, shallow respirations, vomiting, clonic convulsions and methemoglobinemia. Blood transfusion may be life saving.
4. *Atropine* causes flushing, dilated pupils, high fever, dry mouth, and delirium.
 Antidotes—Caffein sodium benzoate, tea, morphine.
5. *Carbolic Acid.*
 Antidotes—Magnesium sulphate, egg albumin. The efficacy of alcohol is questionable.
6. *Carbon-Monoxide*, from illuminating or exhaust gas, produces stable carbon-monoxide hemoglobin, which can absorb no O_2 or CO_2.
 Treatment—Transfusion.
7. *Opiates* produce pin-point pupils and slow shallow respirations. Amount present in common cough mixtures may be toxic in infants.
 Treatment—Stomach washings and caffein.
8. *Lead* poisoning, often associated with "pica," produces anemia, colic, constipation, and occasionally convulsions. The characteristic lead line is rare in children. Stippling of the red cells is diagnostic.
 Treatment[20]—in the *acute* form—fifty to one hundred c. c. calcium chloride intra-

venously daily. This causes deposition of lead in an inert form in the long bones. In the *chronic* form, high calcium diet, including milk, eggs, and vegetables, calcium lactate, fifteen grains every six hours, and active anti-rachitic therapy is given. "Deleading" is instituted carefully at intervals by giving a diet low in calcium—no milk, eggs, nor green vegetables—and producing an acidosis by means of ammonium chloride. Lead salts thus rendered more soluble are excreted. Alkalosis will produce a slower excretion of lead. If, during "deleading" treatment, acute symptoms arise, high calcium diet must immediately be resumed.

9. *Metallic Poisons*, such as mercury and arsenic may produce abdominal pain, diarrhea, vomiting, delirium, dermatitis, gingivitis, bone necrosis, and nephritis.

Sodium thiosulphate in adult doses of 0.3 gm. to 1 gm. two or three times daily is specific if given early and sufficiently.

10. Aikman[21] says that *strychnine* poisoning from accidental ingestion of attractive cathartic pills by young children produces more deaths in New York each year than tetanus and rabies together. The barbitals and apomorphine are specific antidotes.[22]

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DISCUSSION

CLIFFORD O. DUBOIS, M. D., Warsaw: Dr. Miller has given us a veritable storehouse of knowledge in this short paper. The cause of asphyxia has been completely covered in the general terms but specifically it would seem to me that it is due, especially in the outlying districts where I live, to morphine given late, pituitrin, and forceps, one causing the asphyxia by narcosis and the others causing the asphyxia from intra-cranial hemorrhage.

I never practiced or had any patience with the old-time ruthless methods of resuscitation. As to the ultra-modern methods as far as administration of oxygen and CO_2 go, I have no knowledge and I don't believe they are generally used. In fact, I never saw it done.

As to hemorrhage in the new-born, my impression from the literature agrees with the statement that it is due to chemical injury of the reticulo-endothelial system. I take this to mean that hemorrhagic disease of the new-born is really an infection of an unknown type, and I am told that in the hospitals where the infection is kept down to the lowest minimum, hemorrhagic disease of the new-born occurs the least frequently.

I should think that the doctor's suggestion of a routine administration of whole blood at the time of birth would be an excellent thing.

The practical thing for most of us is the subcutaneous injection of Hartman's or Ringer's solution with dextrose in them. It might be even better subcutaneously than intravenously, because it would be taken up more slowly. If the Hartman's solution is unavailable, the ordinary Ringer's made with seven grains of potassium chloride and four grains of calcium chloride to a quart of normal salt can easily be made up any place and can be boiled for sterilization, and if given subcutaneously you don't have to be quite so particular about the character of the water that is used.

I think the most striking thing about Dr. Miller's paper with reference to the treatment of intestinal intoxication, is his omission of the mention of giving solutions intraperitoneally. In view of the wide advocacy of this method of injections of solutions, I wish to read what the author of the method, Dr. Blackfan, said last month:

(As I remember it, Dr. Howland introduced this method from England and it was first carried out by Dr. Blackfan.)

> "I regret that this method has gained such prominence as an avenue for the injection of so many different solutions because it is a non-surgical procedure which may be dangerous when used as a routine.
>
> "Even if the statistical incidence of damage is not high, the more such radical procedure as intraperitoneal injection, direct transfusion lumbar puncture and cephalongrams are used, the more accidents are likely to occur."

He goes on to state that he regrets that he ever had anything to do with the introduction of the method.

Treatment of poliomyelitis by convalescent serum was used seventeen years ago and Aycock mentioned it in his book five years ago, but he now thinks that the value is very questionable.

As to diabetic coma, I wish to ask if he would use forty units of insulin at first and twenty to forty units every hour in small children. I want to quote Woodyatt on the treatment of diabetic coma in a child of thirty-five pounds:

Insulin, 25 units.
100 c. c. warm salt solution by rectum.
150 c. c. fluid by mouth.
30 c. c. orange juice every hour.
Covering each 2 grams of dextrose by one unit of insulin.

Marcus W. Lyon, M. D., South Bend: I was glad to hear Dr. Miller question the therapeutic use of alcohol in carbolic acid poisoning. That subject was investigated a number of years ago and it was found that the chief use of alcohol is to dissolve the carbolic acid, and that alcohol is in no wise an antidote for the acid. It simply puts it in solution and once in solution it should be promptly washed out of the stomach with plenty of water. No one should labor under the delusion that alcohol in any form is an antidote for carbolic acid, because it is not.

Matthew Winters, M. D., Indianapolis: Convalescent sera in poliomyelitis has been used rather extensively and a great deal has been written about it, yet it is rather doubtful whether it has any great value. However, it is the only thing we have which is worth the trial.

I would like to say just a word about acute intoxication in children and emphasize the fact that these cases are hospital cases. To try and treat such a case in the home is more or less suicide to the baby. They are hospital cases because they require so much intravenous and intraperitoneal fluids, and these things should not be done in the home.

Personally, I would hate to see intraperitoneal injections discarded.

You quoted from Dr. Blackfan saying that he was sorry that he had introduced intraperitoneal treatments. I feel sure that this statement was made as a rebuke to the many people who have been using intraperitoneal methods of injecting other materials than saline solution, Ringer's solution, or Hartman's solution.

Dr. Miller, Closing: In regard to the difficult technique of blood transfusion in infants, I think it is largely a matter of being prepared, having your apparatus ready, and having the courage to do it in time. A few years ago Powers gave a masterful review of the treatment of intoxication and in his series (he is a very careful and cautious worker) proved that they reduced their mortality very appreciably by the use of blood transfusion. Even though there is some technical difficulty, I think those of us who have these babies' lives to preserve should master the method.

As to intraperitoneal fluid, our experience is that these severely intoxicated babies are very often moribund when they come into our hands. Fluids, especially blood, very often are not well absorbed from the peritoneal cavity. We have done postmortems on a number of babies who have been given blood and apparently there is very little absorption.

If it is at all possible, if the baby is sick enough, blood should be given intravenously. If the baby is not so sick, with technique that is careful, it is undoubtedly benefited by intraperitoneal transfusions.

THE INDIANA PLAN*

O. N. Torian, M. D.†
Indianapolis

Governor McNutt of Indiana has assigned the Department of Child Health and Maternal Welfare of the state to the Indiana University School of Medicine for its management.

The dean of the college appointed a committee composed of heads of welfare associations, prominent citizens, the president of the State Medical Association, the secretary of the Board of Health, and a representative of the pediatric department of the Medical School—about ten members in all.

It was necessary that all arrangements should be satisfactory to the State Medical Association, and so a meeting was held with its officers and an agreement was reached with them whereby the work of this department is to be done through the Association's organization, calling on the county medical society to approve of and to participate in the program.

At a meeting held May 26, 1933, a chairman was appointed for child health and one for maternal welfare. The State Dental Association requested that it be allowed to participate in the plan and it will arrange a program for dentists. The University Committee anticipates that general medicine and adult specialties will be taught after child health is well under way.

The chairman of Child Health has appointed a chairman for each medical district of the state. He will be the key man to obtain co-operation of the county societies of his district in promoting child health.

It is agreed that the purpose is educative only. With that end in view, it seems best to take the teachers to the doorstep of those desiring postgraduate lectures, and to encourage and plan for each county society to educate its own citizens in child health.

* This plan goes into effect in any locality only upon the request and with the approval of the local county medical society.

† Chairman, Child Health Committee.

INDIANA PLAN FOR CHILD HEALTH AND MATERNAL WELFARE

A Department of State Health Assigned to the Indiana University School of Medicine by the Governor

University Coordinating Committee

W. D. Gatch, M. D., Chairman
George C. Cole, State Superintendent of Instruction
Dr. Joseph H. Weinstein, President Indiana State Medical Association, Terre Haute
Miss Lulu V. Cline, President, Indiana State Nurses Association, South Bend
Dr. E. E. Voyles, President, Indiana State Dental Association, Indianapolis
Dr. O. N. Torian, Department of Pediatrics, Indianapolis
Mrs. Glenn Gifford, American Red Cross, Tipton
Mrs. W. J. Hockett, Indiana Congress of Parents and Teachers, Fort Wayne
Peter C. Reilly, Trustee, Riley Hospital, Indianapolis
Robert E. Cavanaugh, Director, Indiana University Extension Division, Indianapolis
Judge George D. Stiver, American Legion, Goshen
Dr. John H. Hare, Superintendent Evansville State Hospital
Dr. Stanley Coulter, Indiana Tuberculosis Association and Purdue University, Indianapolis

Child Health
Dr. O. N. Torian, Chairman

Maternal Welfare
Dr. A. M. Mendenhall, Chairman

Dental Activities
Dr. E. E. Voyles
Chairman

District Chairmen

1. Dr. Irvin C. Barclay
2. Dr. Homer Woolery
3. Dr. Norman R. Byers
4. Dr. John H. Green
5. Dr. Robert G. Harkness
6. Dr. Harry Plummer Ross
7. Dr. Louis Segar
8. Dr. H. W. Gante
9. Dr. John S. Morrison
10. Dr. O. B. Nesbit
11. Dr. L. B. Rhamy
12. Dr. E. R. Carlo
13. Dr. Milo K. Miller

County Medical Societies

Committees

Post Graduate Teaching
Dr. L. H. Segar, Chairman
Dr. Walter Stoeffler
Dr. Lyman Meiks
Dr. Byron Rust

Immunizations
Dr. Matthew Winters, Chairman
Dr. Herbert Call
Dr. H. B. Mettel
Dr. O. B. Nesbit
Dr. Francis Smith

Pre-school Child
Dr. J. C. Carter, Chairman
Dr. H. P. Ross
Dr. H. W. Gante
Dr. R. R. Hippensteel

School Child
Dr. Milo K. Miller, Chairman
Dr. O. B. Nesbit
Dr. E. R. Carlo
Dr. L. P. Harshman

Child Health and Welfare Organizations
Dr. Robert G. Harkness, Chairman
Dr. Don Miller
Dr. C. A. Curry
Dr. Martha Souter

Tuberculosis
Dr. John H. Hare, Chairman
Dr. Irvin C. Barclay
Dr. G. C. Johnson
Dr. C. C. Wilson

Agreed to by the Indiana State Medical Association and carried out through its organization.

For the present, the University Committee has authorized procedure in the two above educational measures—post-graduate teaching for physicians and lectures to child health organizations. It has also authorized the chairman of Child Health to appoint the following committees to study and develop plans and make recommendations:

1. Post-Graduate Teaching.
2. Child Health and Welfare Organizations.
3. Preschool Child.
4. School Child.
5. Immunization.
6. Tuberculosis.

I. The Committee on Post-Graduate Teaching will procure a team of teachers, using as many local teachers as possible, arrange a program and offer its services to the district chairman. In this way pediatric teaching will be provided for all the doctors of the state, city, small town and country. The committees should investigate other teaching methods in existence. According to the Virginia plan, an all-time physician is employed who travels from town to town lecturing, demonstrating and consulting.

II. The Committee on Child Health Organizations will determine what had best be taught for the mothers' instruction. It will contact the heads of welfare organizations and ask their co-operation whereby the society can best accomplish its purpose of teaching child health to the citizens of its county.

III. The Committee on the Preschool Child will have difficulty in solving the problem of how to reach the child who is launched on his life's career, often beyond the doctor's reach and seldom grouped by any organization, at least in the early preschool ages.

This committee should study the plans of other states and especially that of New Jersey, which suggests reaching this child through circularization from the office of the State Board of Health, enclosing a card mapped out for the doctor's examination. On it is a place for recording immunizations. It also recommends regular periodic examinations until school age. It would be a record of progress if this card were sent to the health board by the school principal on the child's entrance into school.

The committee should also consider the subjects to be taught on the different phases of preschool life and outline lectures on these different phases.

IV. The Committee on the School Child should scrutinize the teaching of health subjects to school children as carried on in different parts of the state; should examine the text books and make recommendations accordingly. The duties of school doctors and school nurses are not well defined and the plan is dissimilar in different parts of the state. There is one best plan for cities and perhaps another for small town and country schools. How far should the school doctor go in his examination and recommendation for his pupils? Treatment should not be one of his duties. What immunizations should be recommended and by whom given? What should be done regarding nutrition and nutritional classes?

V. The Committee on Immunization will have the task of determining what immunizations should be given, the age at which to give them and the method to be recommended. It should be within this committee's province to contact county societies desiring to put on a campaign of immunization, suggest methods and help in any way possible. They should arrange with other committees for stressing their subject as much as possible in the teaching programs.

VI. The Tuberculosis Committee will study the methods of tubercular control among children, recommending a practicable plan for choosing those children who need special examinations and how these children had best be examined. They, too, should concern themselves with adequate instruction to the doctors and laity from a prophylactic standpoint.

These committees should meet immediately, and when plans are adopted by them, they should be forwarded to the chairman of Child Health, who will submit them to the group of committee heads and finally to the University Committee for its decision.

All plans and decisions of the University Committee will be forwarded to the district chairmen, and it is confidently expected that they will push them forward to completion.

EXTRA-UTERINE PREGNANCY: THIRTEEN MONTHS' DURATION

Joe R. Crowder, M. D.
J. Harvey Crowder, Jr., M. D.
Sullivan

The comparative rarity of an abdominal pregnancy reaching term is sufficient warrant for its being reported. According to D'Aunoy and King, the fetus in an abdominal pregnancy can and often does go to full term and may be delivered surgically. If not, the fetus dies, and then may undergo one of the following eventualities: a. skeletonization; b. adipocere; c. suppuration; d. lithopedion formation; and to these may be added mummification and calcification. Paul Titus and J. R. Eisaman of Pittsburgh report an eight-month extra-uterine pregnancy which calcified and was retained in the abdomen for forty years.

Dr. P. Brooke Bland of Philadelphia reports an extra-uterine pregnancy which became calcified and remained in the abdomen for thirteen years; during this time the patient delivered two normal babies at full term.

According to DeLee, Smith reported a calcified

fetus removed from the abdomen sixty years after conception.

In the Stellner case, the fetus of an extra-uterine pregnancy was retained for twelve years and then became suppurative and discharged through the bladder.

Klingenschmidt reported a case of fetal bones removed through the rectum seventeen years after pregnancy.

Masson and Simon reviewed the literature in 1928 and reported 174 cases, and reported nine from the Mayo Clinic.

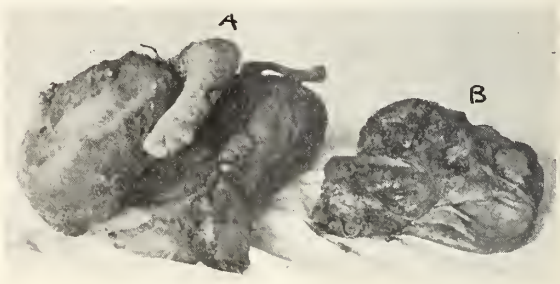
According to Harrar abdominal pregnancies have come to term in ten patients in 156,000 confinements at the New York Lying-in Hospital. Several cases have been reported where the pregnancy went to full term, was delivered surgically, and lived.

Etiologically, an arrest of a fertilized ovum at some point between the uterus and abdominal cavity, and a more or less complete development, constitutes an extra-uterine pregnancy. Among the theories explaining this mechanical interference with the downward progress of the fertilized ovum have been advanced the following: adhesions resulting from inflammatory diseases of ovary, tubes, or pelvic peritoneum, diverticula in the tubes, interference with the normal peristalsis of the tubes from any causes, and preliminary decidual development in the tubes.

Case Report

When you are presented with the history that the patient has been pregnant for thirteen months without any interruption, you are immediately presented with a problem which needs careful study. One may recall cases with such a history in which an attempt was made to deliver the fetus by cervical dilation and bags with a fatal result from hemorrhage because the pregnancy was extra-uterine. On the other hand, one may undertake an abdominal route and find later that he has subjected the patient to a procedure much too severe for the subsequent findings. Such was our problem when Mrs. R. G., age 29, an American, housewife, was admitted to the Mary Sherman Hospital, Sullivan, Indiana, July 21, 1932. Family history was negative. Personal history was essentially negative. She had been married for eight years but there was no previous history of pregnancy. Menstruation was of the regular twenty-eight day type until and including June 21, 1931; duration three to five days; moderate flow, with slight pain. Clinical history: Last menstruation June 21, 1931. Beginning August, 1931, patient began to have a slightly blood-tinged mucous discharge with slight nausea at this time. This continued until the early part of September when the patient was seized with a sharp pain in the right lower abdomen and was in bed for one week with a slight fever and vomiting. These symptoms gradually subsided and the patient was apparently in good health. She felt life for the first time December 19, 1931. From January to April 10, 1932, she felt very well and had no discharge whatever. April 10th was the last day that the patient felt life. At this time the discharge reappeared, the abdomen became slightly tender and a feeling of heaviness was present. Since April the abdominal mass has become smaller.

Examination revealed a rather healthy looking female. Temperature, 99.6; pulse, 88; respiration, 20. The head, neck, and chest were essentially normal. Upon palpation of the abdomen, a hard, symmetrical mass about the size of a seven months



A. Fetus. B. Sac.

pregnancy could be felt. The mass had the consistency of a fibroid. Fetal heart tones were absent. Vaginal examination revealed a very firm cervix which was high and difficult to reach. Posteriorly a thin walled mass containing hard masses could be felt.

Laboratory findings: Hemoglobin 60%; white blood count 7,800; red blood count 3,640,000.

X-ray findings: A fetus with an elongated head; the head in left upper quadrant.

Operation: Laparotomy was performed through a median incision, and upon opening the peritoneal cavity a large reddish gray mass was encountered, to the surface of which were attached numerous adhesions. These adhesions extended to the omentum, intestines, uterus, vaginal wall, and broad ligaments on both sides. The uterus was found lying somewhat below and to the left of the center of the tumor, and firmly adherent to its anterior wall. It was the size of an ordinary non-pregnant uterus. Neither the right nor the left tube could be followed to the fimbria ovarica. Because of the adhesions, the left ovary was not identified. The mass was opened and a 5½ pound dead fetus was removed. The opening was closed and the entire mass was removed from the surrounding structures by blunt dissection. The uterus was removed because of the denudation of the posterior aspect of the uterus which made it impossible to have satisfactory apposition of the peritoneal surfaces.

Peritonization was completed after hysterectomy and the abdomen was closed with a one tube drainage.

Recovery was uneventful.

Pathological report: The specimen consists of chorion. Some portio are viable; but the buds are inanimate, with hyaloid changes and traces of calci-

fication (suggesting lapse of time after death). The sinuses contain dense fibrin. Findings fail to differentiate oviduct or ovarian gestation.

Conclusions

We believed that the history was correct and that we were dealing with a post-term pregnancy. Whether this was intra-uterine or extra-uterine was to be decided in order to reach a plan of procedure. The x-ray revealed that there was a fetus with the head in the left upper quadrant. Iodized oil injections into the uterine cavity should have been our next test. Since the cervix was so high and firm, we were of the opinion that the abdominal route was the route of choice. The picture is that of a post-term extra-uterine pregnancy. It appears that the patient became pregnant between June 21, 1931, and July 19, 1931; that the ovum implanted itself upon the ampullary portion of the right tube; that early in September there was a rupture into the peritoneal cavity but that there was partial retention to the original implantation; that fetal movements were noticeable about December 19, 1931; that full term was reached early in April, 1932; and that death occurred about April 10th; that after death, skeletonization began.

The case is that of a thirteen month extra-uterine pregnancy removed by the abdominal route along with a pan hysterectomy, with a complete and uneventful recovery of the patient.

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(Three papers from the Mayo Clinic, presented before an Indiana University Seminar, are published in this issue. Three of the series of six appeared in the July number.)

ETIOLOGIC AND PATHOLOGIC APPROACH TO THE DIAGNOSIS OF HEART DISEASE*

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Medicine is as much an art as it is a science and on that account will continue to be taught to a large extent by precept. The art consists for one thing in the ability to deal with approximations rather than absolute facts. A successful clinician needs a mental equipment which is a combination of that required by a detective and a diplomat.

The uncertainty in the diagnosis of cardiac lesions that exists among graduate as well as undergraduate students often arises from the fact that they are attempting to diagnose a pathologic condition almost altogether on the character of a murmur. More than half of the diagnoses of cardiac disease have to be made with more or less complete disregard of murmurs. Moreover, there are only two murmurs diagnostic of cardiac lesions, one the diastolic murmur of aortic regurgitation and the other the presystolic murmur of mitral stenosis. If a student has enough opportunity to hear these murmurs he will recognize them, and if not, no amount of didactic discussion will enable him to do so.

Modern studies in cardiology have shown that most of the heart disease encountered in practice may be classified as resulting from one or more of the following causes: hypertension, coronary sclerosis, rheumatic fever, syphilis, and hyperthyroidism. The first thing one should ascertain if possible when attempting to evaluate cardiac injury is what etiologic factor or factors are present in the case that are capable of causing heart disease. Having ascertained that, one should next project the pathologic picture that can ensue from any of these causes, bearing in mind the effect of sex and age on the type of lesion that may be anticipated.

What pathologic picture presents itself when rheumatic fever is present? A lesion is visualized which had its inception, generally, between the ages of five and fifteen years, and only occasionally after the age of thirty years. Few patients succumb to the acute attack of rheumatic fever, or even to the first few exacerbations, but the disease goes on to a chronic development compounded of recurring acute and subacute attacks of rheumatic fever leading to gradual cicatricial narrowing of orifices of the valves, to myocarditis, and to pericardial involvement in from 15 to 20 per cent of patients who have the chronic form of the disease. Rheumatic heart disease occurs more frequently among women than men, in about the ratio of 5 to 4. The mitral valve only is involved in 41 per cent of cases, the aortic valve only in 18 per cent and the aortic and mitral valves together in 30 per cent. In an additional 5 per cent the tricuspid valve is involved, in conjunction with disease of both the aortic and mitral valves. Involvement of the mitral valve only occurs approximately twice as commonly among women as among men. Few patients with rheumatic mitral endocarditis are free of cardiac symptoms beyond the age of forty years. Aortic stenosis, a rheumatic lesion encountered four times as frequently among men as women, is consistent with freedom from cardiac symptoms for a

* Abstract of paper presented before the Indiana University Seminar, Indianapolis, March 25, 1932.

much longer period of time than mitral stenosis. Chronic endocarditis is commonly the soil on which subacute bacterial endocarditis is engrafted, a fact that must always be borne in mind in projecting the pathologic possibilities in a case of rheumatic endocarditis.

Syphilis of the heart is confined practically to involvement of the aorta. Syphilis may lead to aortic regurgitation, aortic aneurysm, or narrowing or closure of the mouths of the coronary vessels. It is important to note that syphilis never leads to aortic stenosis. Gumma, and diffuse exudative inflammation in the myocardium, occur rarely. Syphilitic aortitis is more common among men than women. There is a latent period of about twenty years from the time of the initial lesion of syphilis until signs and symptoms referable to the heart, leading to the diagnosis of aortic involvement, appear. This means that syphilitic heart disease will be discovered usually in or near the fifth decade of life.

Hypertensive heart disease results from prolonged cardiac overwork incident to increase in blood pressure. In the beginning, the left ventricle undergoes hypertrophy, and the roentgenogram gives evidence of a boot-shaped enlargement of the left ventricle, due to rounded contour of the apex. Failure of the left ventricle is followed by hypertrophy of the right ventricle, and dilatation and hypertrophy of all the chambers of the heart occur in the final stages of heart failure. Systolic apical murmurs are frequently observed when dilatation of the left ventricle occurs. Coronary sclerosis is a complication in a high percentage of the cases in which the heart is injured by hypertension, and it accounts for about 15 per cent of deaths. Death occurs in two-thirds of cases of hypertensive heart disease from congestive heart failure. Myofibrosis of the myocardium is observed in those hearts which are the seat of advanced coronary sclerosis. Myocarditis is not observed in uncomplicated cases.

Coronary sclerosis may complicate hypertensive heart disease, or it may occur independently. It is essentially a disease of the larger coronary vessels, and represents a process of aging. Intimal thickening of the coronary vessels occurs often asymmetrically in the form of atheroma. Gradual, partial or complete occlusion of a coronary vessel results in atrophy of the muscle fibers and replacement with fibrous tissue. If sudden closure occurs, acute myocardial infarction results. Rarely the heart ruptures at the site of softening, leading to sudden death. Acute pericarditis develops in from 12 to 15 per cent of cases of acute myocardial infarction, giving rise to a friction rub. A mural thrombus may form at the site of the infarct, portions of which may be dislodged and produce arterial emboli. In a high percentage of hearts of patients who survive acute coronary occlusion there is fibrous replacement of the infarcted heart muscle, with satisfactory restoration of cardiac function.

Hyperthyroidism causes tachycardia, cardiac arrythmia, particularly auricular fibrillation and increased pulse pressure, due chiefly to elevation of the systolic blood pressure. It seems that most of the cardiac failure seen in cases of hyperthyroidism is found among patients whose hearts are the seat of other types of organic disease. However, hypertrophy of the heart is encountered in cases of hyperthyroidism, particularly in cases of long standing in which there is no basis for increase in size or congestive heart failure other than hyperthyroidism. Aside from occasional instances of hypertrophy there is no constant cardiac pathologic change in hyperthyroidism. The chief thing to bear in mind is that hyperthyroidism is a frequent precipitating cause of cardiac failure and its presence may be overlooked, because it is overshadowed by the symptoms and signs of cardiac disease.

THE FUNCTIONS OF THE SPLEEN*

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To Galen is ascribed the statement that the spleen is an organ of mystery. Although it cannot be said today that this organ does not have unknown functions, much more is known concerning its physiology than was known a few years ago. It is my purpose to tell of a few of the more important recent advances in knowledge of the physiology of this organ. I must necessarily be brief and many phases of the subject that might be of interest will be omitted. Although one must be proud of this rapid increase in knowledge concerning the physiology of the spleen, it must be admitted that little of it can as yet be applied to the diagnosis or treatment of its diseases.

Early hypotheses concerning splenic function were mainly conjectures, but it is interesting to note that some of these conjectures have been proved to be true by experimental investigation. Few organs of the body are mentioned more often in literature than the spleen. An excellent presentation of this consideration of the spleen has been made by Inlow,[9] a native of Indiana. Even in the literature there is much of contradiction in the conception of functions of the spleen. Some of the earlier scientific treatises on the anatomy of the spleen or its possible function are valuable as literary models as well as for their subject matter.[2 3 4 5 20]

A consideration of the comparative anatomy of the spleen is of interest. Probably no other organ in the body varies so greatly in size, shape, color and so forth, in the various species. The relation of weight of spleen to weight of body may vary from 1 to 200 in some species, 1 to 3,000 in other species. In shape it may vary from a small sphere to a designless irregular mass; in color, from a pale pink to a deep purple. An interesting and probably

* Read at the Indiana University Seminar, Indianapolis, Indiana, March 25, 1932.

important anatomic fact is common to all species of animals possessing a spleen; namely, the blood from the organ drains into the portal circulation.

A few facts concerning the anatomy of the spleen are pertinent to its physiology. First, it must be considered as the largest single mass of lymphoid tissue in the body. As such, it probably carries on the same function as lymphoid tissue elsewhere in the body. It is the site of a considerable amount of the reticulo-endothelial system of the body. The reticulo-endothelial cells of the spleen probably carry on the same functions as the same type of cell situated elsewhere in the body, as in the liver and bone marrow.

One of the most important anatomic considerations of the spleen from the physiologic standpoint is its circulation, since the main activities of the organ have to do with the blood. When the circulation of the spleen is considered from the standpoint of comparative anatomy three types are noted: the closed type, the open type, and a combination of the two. Closed circulation means that the blood flows directly from the arterioles through the sinuses into the venules, never being outside of channels lined with endothelium. Open circulation is the flow of blood from the arterioles into the splenic pulp or spaces unlined with endothelium to reach the lumen of the veins through their incomplete walls. In the combined type some of the blood can flow through definite channels and some into the splenic pulp. Examples of these three types of circulation can be found in various species of animals. The partly open and closed type is probably the one occurring in man.[17]

The spleen was probably the first organ to be removed both experimentally and clinically; it is said to have been removed experimentally in 1680 and clinically in 1549.[12,17] One reason why knowledge of the function of the spleen has been so difficult to obtain is because its loss is followed by so few demonstrable changes. The spleen is not a vital organ, that is, its removal under ordinary conditions is not followed by death. Only recently has a condition been discovered in which loss of the spleen is fatal.[18] Numerous investigations have been made on the effect of removal of the spleen, but the few changes observed can be given briefly.

As previously stated, most of the known functions of the spleen have to do with blood. In fetal life in most species of animals it functions as a hematopoietic organ. In some species in which bone marrow is either lacking or scant in amount it produces erythrocytes throughout life. I have removed most of the spleen from fish and noted gradual development of anemia which may become extreme before the remnant of splenic tissue undergoes sufficient physiologic compensation to produce the normal number of erythrocytes. In most species of animals so far studied, however, splenectomy is followed by only slight, if any, anemia.

Removal of the spleen is followed by slight, transient, but definite changes in the bone marrow, both erythrogenic and leukogenic activity being increased.[11] This increase is noticeable about two weeks after splenectomy; reaches a maximum in five to six weeks and has disappeared by the tenth week. Splenectomy is also said to cause changes in the lymph nodes, hemolymph nodes, and thymus gland.[13] In my experiments such tissue did not show consistent demonstrable changes after removal of the spleen. Occasionally a very definite change is observed, particularly in the lymph nodes which become markedly pigmented, due probably to increased destruction of erythrocytes. In some species of animals similar changes in the reticulo-endothelial cells of the liver also occur. The cause for these variable results cannot be explained, although the most satisfactory hypothesis is that the splenic tissue is only a part of a large mass of similar tissue in the body, and only under rare conditions does its removal decrease such tissue sufficiently to bring forth a demand for physiologic compensation. In my experiments even removal of the major part of the spleen in cases in which an accessory spleen was present has not produced enlargement of the latter.

One of the earliest hypotheses concerning the functions of the spleen was that it had a co-ordinating action in relation with the digestive glands, the stomach, pancreas and liver. In spite of the numerous researches such a function has not been demonstrated, and more recent work would tend to show that this hypothesis is untenable except possibly in relation to the secretion of one constituent of bile, the bile pigment.[8]

It was noted early that the function of the spleen was to act as a reservoir for blood, and recent work has amply demonstrated this function to be very important. Several years ago Drips and I found that during hibernation the spleen exhibited a characteristic appearance. Within twelve hours after an animal became torpid the spleen was greatly enlarged and filled with blood, the capsule became tense, and the tissue friable. Later I noted that the spleen of a dog trained to laboratory conditions appeared much larger when exposed under local anesthesia than when exposed under general anesthesia, or as seen at necropsy.

Several years ago Hargis and I attempted to investigate the possible rôle of the spleen during digestion. In order to decide whether the contractile power of the spleen was related to the digestive functions it was necessary to devise a method for measuring the volume of the spleen in the relatively intact dog. Hargis accomplished this by devising a flexible chamber in which the spleen could be placed and which would heal in place, permitting observation on changes in splenic volume to be made over long periods of time. With the dog under ether anesthesia it was relatively simple to encase the spleen in a mould, or plethysmograph, as it is usually called. When the animal had recovered from the immediate effects of the operation, changes in the volume of the spleen were

recorded by connecting the plethysmograph with a recording device for measuring changes in the air pressure surrounding the spleen. Since the system is air-tight, any increase in the size of the spleen is manifested by a corresponding increase in the intraplethysmographic pressure. The importance of this technic lies in the fact that these procedures need not inconvenience the animal in any way and he is readily trained to lie quietly during measurements.

In studies on the volume changes of the spleen in the intact animal, what may be termed the splenic reflex was found. It was noticed that when anyone entered the room there was an instantaneous momentary decrease in the volume of the spleen followed usually by an increase. The result could be evoked by such stimuli as clapping of the hands, banging the door, and ringing a bell. After the animal had become accustomed to these stimuli they had to be intensified to produce any effects. However, the splenic reflex could always be evoked by an unusual stimulus to which the animal had not become accustomed.

Many years ago Roy found that the spleen underwent rhythmic contractions similar to the rhythmic movements of the intestine. It was easy to demonstrate that these rhythmic contractions were different from the contractions which had been found to occur following extraneous stimuli. When the nerves to the spleen were sectioned, the latter did not occur; however, the rhythmic contraction persisted. Evidently, then, the spleen has two forms of contraction. A more or less constant rhythmic alteration in volume of a slight degree which does not depend on the central nervous system, and marked contraction producing a great decrease in volume as a consequence of some extraneous stimulus mediated through the nervous system.

All of these observations indicated that the normal spleen of an animal which had not been excited in any manner was much larger than had been thought by observing the organ at operation under general anesthesia or after death. They also proved that the spleen underwent marked and rapid changes in volume depending on external stimuli.

That the spleen could function as a reservoir for blood was completely proved by Barcroft. During an expedition to the Andes for the purpose of studying acclimatization to high altitudes, Barcroft had occasion to make repeated observations on his blood volume. His blood volume had always been constant but as he approached the equator there was an increase. In seeking an explanation for this considerable increase in blood which had been stored in the body, he considered the spleen as a possible agent, and subsequent investigation proved that this organ was a reservoir for an unexpectedly large amount of blood.

That the spleen actually had this function of harboring blood out of the active circulation was first demonstrated by subjecting animals to an atmosphere of carbon monoxide. Although the blood at the time of death contained a very high percentage of gas, the hemoglobin in the spleen contained practically none. Conversely, it was found that once the hemoglobin in the splenic pulp had taken up carbon monoxide, it retained this gas much longer than the general circulation. These observations clearly proved that the spleen contains stasis blood, and that the bulk of the contained blood is not actively circulating, but the increases in blood volume which Barcroft had noted on his expedition were thought much greater than could possibly come from the spleen, as judged by the size of the spleen at necropsy. It was concluded that either some other source of blood was readily available, or that the spleen during life was much larger than experiments on anesthetized animals had indicated.

Therefore the size of the spleen in normal intact dogs and cats was measured. For this purpose a celluloid abdominal window was prepared in cats, and it could readily be seen that the spleen of the cat a week after this operation was much larger than any investigator had previously believed. The experiment was repeated by exteriorizing the spleen without the use of an abdominal celluloid window. This was done by stitching the edges of the spleen to the surrounding skin of an abdominal incision. It was now a very simple matter to study the factors influencing the size of the spleen, after the organism had recovered from the immediate effects of the operation.

The spleen of an animal was much larger under these conditions than it was under anesthesia or after death. The amount of blood the spleen could hold was quite large, being estimated as one-sixth of the blood volume. It was also found that the spleen underwent marked fluctuations in size in the course of the day, and corresponding alterations of blood volume could be demonstrated. During hemorrhage, asphyxia, narcosis, or muscular exercise of varying degrees of severity, the spleen underwent vigorous contraction. Various psychic states reflected themselves in the size of the spleen. When the dog was alarmed by a loud noise, or some untoward incident occurred, the exteriorized spleen promptly shrank. When the dog was kept quiet the spleen maintained its normal size.

These investigations of Barcroft have been greatly amplified by himself and by other workers employing several species of animals. There is no question that the normal spleen is larger than had been anticipated; that it contains a significant amount of blood, and that this blood may be made available to maintain the circulation under certain conditions. The full clinical significance of these facts have yet to be determined. However, it can readily be recognized that the immediate addition of a fairly large amount of blood to the circulation in an emergency as postulated by Izquierdo and

Cannon would be of great value. The conception of a large amount of stasis blood in the spleen, in which certain organisms could remain sequestered out of the main circulation and multiply, may be of importance in explaining the method of development of some of the splenomegalias.

Since the spleen is the largest single mass of lymphoid tissue in the body, the functions which this tissue maintain can also be ascribed to the spleen. The same statement holds for the reticuloendothelial system. Consequently, the spleen is of importance in the formation of bile pigment,[15] storage of iron, possibly in immunity, and other less clearly defined functions.

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ROENTGENOLOGIC DIAGNOSIS OF CARCINOMA OF THE COLON*

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By the employment of appropriate and properly executed technic and thoughtful interpretation of the phenomena elicited, the roentgen ray can be made to contribute as much to the diagnosis of carcinoma of the colon as to the diagnosis of carcinoma of the stomach.

TECHNIC

One of the earliest methods of examination of the colon was with the opaque meal. This still has its special applications, but is unsuitable as a routine and is contraindicated when obstruction is suspected, for the medium may become impacted above the point of stenosis. To demonstrate the luminal deformity which attends most organic diseases of the colon, especially carcinoma, the opaque enema is the procedure of choice.

Satisfactory examination with the enema depends largely and primarily on adequate preparation of the patient. It is imperative that the colon be cleared of fecal remnants, fluid and gas before attempting investigation. This entails purgation and the employment of cleansing enemas. Saline cathartics are undesirable because by osmosis they draw fluid into the bowel to the point of distention and subsequent evacuation is likely to be incomplete. Irritant purgatives are also undesirable because they are not uniformly efficient and tend to induce prolonged irritability of the bowel. Castor oil seems to be the most uniformly efficient purgative available. In our own routine the patient foregoes the evening meal and takes 60 c.c. of castor oil.

* Synopsis of paper presented before the Indiana University Seminar, Indianapolis, March 25, 1932.

Next morning before examination the colon is cleansed with physiologic sodium chloride enemas. This routine is almost always satisfactory and is broken only for patients who have severe diarrhea, intestinal hemorrhage, or marked obstruction. If the patient has difficulty in retaining the enema, or if considerable intestinal spasm exists, the administration of an antispasmodic to full physiologic effect is often helpful. Tincture of belladonna has proved efficient and reliable. A convenient and dependable method is to give 60 drops of the tincture, divided into three equal doses, two of which are taken at an interval of two hours the evening before examination, and the remaining dose an hour before examination.

Preparation of the enema also deserves careful attention. The opaque material should be in sufficient quantity, minutely divided and maintained in good suspension. Plain aqueous suspension is inadequate. Effective commercial preparations of barium sulphate are available, or acacia may be added to the barium in preparing the enema. The consistence of the mixture should approximate that of heavy cream. Especially important is it to keep the enema at or slightly above body temperature because the colon reacts violently at times to cold injections.

With the patient supine on the table the enema is introduced slowly and steadily, and its progress is constantly observed on the screen until the column fills out the cecum and terminal coils of ileum. As the examination continues the patient is turned from side to side to obtain views at different angles, and inspection is further assisted by free palpatory manipulation. Often roentgenograms are desirable for the supplementary information which they may afford. Ordinarily, they are made with the patient prone, but other positions or some form of compression may project the lesion to better advantage. It should be emphasized, however, that roentgenography alone is not reliable for the demonstration or exclusion of disease of the colon.

Although roentgenoscopic study of the colon with the barium enema is the basic procedure and will suffice for the revelation of most lesions, certain additions and modifications are sometimes advantageous. For example, a combination of the opaque meal and opaque enema is sometimes employed and is occasionally applicable in certain nonobstructive conditions. The meal has also been employed to show the proximal limits of carcinomas which completely obstructed the enema, but it should be used sparingly, if at all, for it is likely to accumulate in an insoluble mass proximal to the obstruction and greatly enhances the hazard of operation. Air and inert gases have also been injected into the bowel to show its contours, but the picture lacks the distinctness necessary for routine diagnostic work. Fischer, in 1922, began to use air in conjunction with the opaque enema. The enema is largely evacuated but sufficient barium remains to coat the luminal surface of the bowel, and when air is injected the internal relief is exhibited more or less plainly.

My associate, H. M. Weber, has developed several technical modifications of Fischer's method which enhance its value. By the improved method the enema is administered under fluoroscopic control and studied as usual. The patient is then required to evacuate the enema as completely as possible, but a coating of barium remains on the intestinal wall. Then the colon is inflated with a hand-blower, care being exercised to avoid overdistention. The roentgenoscopic image may be informative but lacks sufficient detail for accurate diagnosis. Accordingly, as soon as the cecum becomes moderately distended, the tip of the insufflator is removed and stereoscopic roentgenograms are made, using the grid diaphragm. Properly applied, the method affords a view of the internal surface of the colon second only to that obtainable by proctoscopy or necropsy, and is especially effective in the revelation of polyps and other small lesions.

Early Carcinoma

From authentic histologic studies it is known that many grossly benign polypoid growths are in fact carcinomatous, and it has been shown definitely that at least some malignant growths of the colon have their beginning in these macroscopically benign pedunculated tumors. This is the earliest stage of malignant disease that roentgenologic examination is likely to uncover. A notable feature of these lesions is their failure usually to produce deformity of the contour of the colon. When they are relatively large and situated in segments accessible to palpation they may be roentgenoscopically demonstrable. A momentary split in the barium column as the enema ascends is sometimes the sole apparent indication of a polypoid growth. Approximating the walls of the colon, however, will bring out the central defect with its characteristic smooth, sharp, rounded or ovoid contour. The wall of the bowel remains pliant, peristalsis is not altered, and only rarely is the tumor palpable. Notwithstanding the numerous cases in which the growths are sufficiently large to be demonstrable, it is probable that polypoid lesions 2 cm. or less in diameter will almost always elude discovery by ordinary examination with the enema. For the demonstration of these and to assure discovery of the larger polypoid tumors, the double contrast method is especially efficient.

By this procedure polypoid growths, whether single or multiple, are depicted as rounded projections into the intestinal lumen. Their contours are outlined vividly in the air-distended bowel, the topography of their surfaces is often evident, and any ulcerous excavation suggestive of malignancy is likely to be apparent.

Advanced Carcinoma

Most patients with carcinoma of the colon are not sent for roentgenologic examination until symptoms have become rather pronounced and the disease is fairly advanced. At this stage, with the opaque enema alone the lesion is usually not only apparent but its differential characters are manifest as well.

The essential roentgenologic sign of advanced carcinoma is the filling defect, which may be central or marginal. It is caused chiefly by protrusion of the growth into the lumen of the bowel, partly by diminished distensibility of the infiltrated wall, and partly by spasm aroused by the lesion. The picture, in fact, is the shadow of a barium cast of which the intestinal lumen is the matrix. Necessarily, the picture and the appearance of the defect will vary according to the morphologic character of the growth.

Scirrhous carcinoma produces a short and concentric defect, and its annular character is its most prominent feature. Ulceration is seldom demonstrable and fixation to adjacent organs is rare, so the growth is usually quite mobile. Ordinarily, the tumor is so small that it is not palpable, although if the preliminary preparation has not been thorough a mass of fecal material proximal to the lesion may be felt. Obviously, demonstrability of the annular defect will depend on the degree of patency of the affected segment. If the constriction is pervious to the enema, yet considerable obstruction exists, dilatation of the bowel proximal to the tumor will be apparent. Frequently these annular lesions, although they have permitted the fecal current to pass, offer complete obstruction to the enema, the pressure of which produces a short intussusception and thus increases the stenosis. In such cases the barium column ends in a smooth convex eminence on each side of the tumor. However, the stenosis itself may be sufficient to obstruct the enema, and in that event the barium column terminates in a smooth or ragged cone.

Medullary carcinoma varies in its appearance, depending on the size of the growth, extent of ulceration and amount of mural infiltration. Deformity of the luminal contour is less striking than the evidence of lobulated cauliflower-like masses thrust into the lumen. Ulceration is shown, under palpation, by masses of barium persisting in deep craters. In the proximal part of the colon the growth commonly involves only a portion of the circumference; in the distal segments it is likely to affect the entire circumference.

Gelatinous (mucoid) carcinoma produces a long constriction of the segment affected. The channel through it is jaggedly irregular and tortuous. Demarcation between tumor and normal tissue is abrupt. Usually the tumor is palpable and the mass feels indurated and knotty. Fixation may be present or absent. Retrograde obstruction may occur and in this event the opaque column terminates in a sharp prong on each side of the distal end of the channel through the tumor.

Differential Diagnosis

When a defect in the colonic shadow is observed the first task is to determine whether it is due to a lesion or to other causes, such as spasm, fecal material, fluid or gas. Spastic defects tend to change in form or situation, can sometimes be effaced by manipulation, and seldom survive at re-examination or after the administration of belladonna. Fecal matter, fluid and gas are also usually displacable by palpation and the defects they produce are not constant in outline. If all such simulants can be excluded and it is certain that the defect represents an organic change, probably carcinoma, the latter must be distinguished from various other lesions, such as diverticulitis, hyperplastic tuberculosis, and chronic ulcerative colitis.

Diverticulitis is commonly restricted to the sigmoid segment. Near the gross lesion diverticula, appearing as knob-like projections from the lumen, are usually visible. The narrowed channel through the relatively long inflamed segment is concentrically serrate and the segment is flexible.

Hyperplastic tuberculosis, like other specific granulomas, is pre-eminently a disease of the cecocolon, and affects this region extensively. The diseased and normal portions merge indefinably without definite demarcation; the narrowed channel is central and rather smooth; if the hyperplasia is palpable it is boggy, not firm, and although the lesion is usually fixed it is pliable.

Rarely chronic ulcerative colitis involves only a single small portion of the bowel, and has considerable resemblance to carcinoma. However, the lesion usually manifests marked irritability, has a relatively broad channel with smooth margins, and is pliable in spite of the pronounced mural thickening.

In conclusion, it is worthy of note that 10 per cent of all malignant lesions occur in the colon or large bowel. Many failures in treatment are attributable primarily to the late stage at which the lesion is commonly recognized. Roentgenologic methods make it possible to discover carcinoma in its early stages, often before there is clinical evidence of the growth. Hence a roentgenologic examination of the colon should be made, not only when abdominal symptoms are slight or indefinite, but in the course of the regular yearly examination of adults.

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AUGUST, 1933

EDITORIALS

THE OCULAR THERAPY OF HOLOCAINE

Holocaine, by no means a new drug, seems not to have received the attention it merits, particularly in connection with diseases and injuries of the eye. While it is generally charged with being more toxic than cocaine, yet in our experience we have never observed any untoward effects from its use. Like many other similar anesthetics, holocaine solution is not very stable and should be freshly made every few weeks; if kept in a porcelain container, its efficacy is greatly enhanced, since there seems to be a chemical reaction between holocaine and certain constituents of glass.

The use of holocaine as an anesthetic in eye cases is further enhanced by the fact that it has a very decided antiseptic quality. Again, it possesses certain advantages over cocaine, because of the fact that it has a rather marked astringent action on the corneal epithelium, while cocaine has a tendency to produce some degree of maceration of this tissue, predisposing to ulceration. A further advantage is that there is no undermining of the cut edges of the corneal epithelium as is the case with cocaine.

Used in a two per cent watery solution, holocaine "takes effect" readily, though there is usually a bit more irritation of the eye for a moment than in the use of cocaine. In ointment form we have found it more efficacious when combined with epinephrine, especially when used after the removal of foreign bodies. It is in these cases that we have had the greater experience in its use. It is invariably instilled, in ointment form, after the removal of a foreign body, and at once creates a sense of comfort and well-being in the eye. Used in this manner, holocaine saves the oculist much time, for it is rare that a patient returns a few hours after a foreign body has been removed from the cornea, complaining that there is "something still there." Its antiseptic properties are not to be overlooked in this connection.

A few years ago Verhoeff stated that he was of the opinion that holocaine was a specific in many corneal diseases; in particular did he recommend it in keratitis of the herpetic type; we have used it in many of these cases with uniformly good results; in fact, holocaine plays an important role in the treatment of all corneal conditions as met in our practice.

For some years we were much perturbed over the unsatisfactory immediate results of treatment in irritations of the eye due to exposure to strong light, especially the various welding lights; the reactions from such exposure coming late at night added naught to one's comfort. More by accident than by design, we made the discovery that holocaine-epinephrine ointment was a specific in these cases; the patient had immediate and lasting comfort and we felt secure in the belief that there was no untoward effect from a continued use of the treatment. Having later supplied the first-aid departments of various plants with a liberal supply of the ointment, we do not see many of these cases any more.

A few years ago one of our oil refineries began working a certain Texas crude oil, which had high sulphur content, and as a result a large amount of hydrogen sulphide gas was released. This gas had a very untoward effect on the eyes, bringing about a generalized conjunctivitis that was very painful and not submissive to the usual treatment, and there was a time loss of two to three days in connection with each of these cases. After a considerable period of investigation of the problem, and after trying various remedies, it occurred to us that the holocaine-epinephrine ointment might be of service; a brief experience sufficed to prove that we had solved the problem, and we are advised that this is the treatment in general use in oil refineries having to do with this particular crude oil.

A more recent experience is that of so-called Fourth of July eye injuries, principally those in which there are gunpowder burns about the conjunctive and cornea. In addition to the usual treatment, not overlooking tetanus antitoxin, we have used the holocaine-epinephrine ointment, much to the comfort of the little folks who most commonly suffer this type of injury.

Holocaine is not a general panacea, as might be suspected from the eulogistic expressions above, but the fact remains that, judiciously used, it will prove a valuable addition to our armamentarium in ocular therapy.

THE REPORTING OF COMMUNICABLE DISEASES

Every physician is familiar with the question, "Is there a good bit of sickness in the neighborhood,

Doc?" When folks have nothing to worry about in their own families, they begin to wonder what the general condition of the community may be. This universal interest in the health of the surrounding neighborhood is of inestimable value to those who have the responsibility for the public health on their shoulders, and the interest should be nourished.

The Bureau of Communicable Diseases of the Division of Public Health (the State Board of Health), is making a strenuous effort to bring the reporting of infectious diseases up to the standard of efficiency required for entrance into the Morbidity Registration Area of the United States and deserves the support of every physician and health officer in Indiana in this praiseworthy endeavor. Indiana was the first state west of the Allegheny Mountains to be admitted to the Death Registration Area (Michigan was admitted the same year, 1900), and has been in the Birth Registration Area since 1915. It is unthinkable that we should remain outside of the Morbidity Registration Area when twenty-nine other states are members, and indeed practically every one of the other Northern States. The manner of classification of the states is roughly as follows: The number of deaths from each of the reportable diseases is known for each state; likewise, the number of reported cases of the same diseases. If, for example, the number of reported cases of diphtheria per death from the same disease is twelve, as is determined by averaging the results from all of the states over a period of three years, then Indiana to be admitted must have twelve times as many reports of disease as there are deaths. The same applies for other diseases as typhoid fever, smallpox, scarlet fever and the like. As soon as Indiana comes up to 100 per cent of the average, we shall then be admitted. At present we stand at about 87 per cent of the average, and therefore, are within easy striking distance.

The manner of making these reports is undoubtedly familiar to every physician and will not be repeated at this time. Then each week the local health officer tabulates the reports and sends the total to the Division of Public Health. There they are arranged by counties and by diseases and the total sent to Washington. Likewise, a report for the preceding week is prepared for distribution in this state. There are those who see no useful purpose in going to this trouble. We believe, however, that it is the duty of every physician and health officer to co-operate in this work. In the first place it is the law that they shall do so and the reasons for that law are good, as is proved by the fact that every civilized state and nation has seen fit to make such laws. In the second place the installation of isolation and quarantine will be impossible unless the physicians report their communicable diseases to the health officers. The rights of the community are involved here. In the third place, the agencies charged with the responsibility of maintaining the health of the people of the state must know what diseases are prevalent and what communities are affected. In case a practitioner cannot or will not report his communicable diseases as he finds them, he does not deserve the right to practice medicine; when a health officer cannot or will not report his cases as he is required by law to do, he should be displaced by some one who will. We are painfully aware of the fact that health officers are underpaid, and it is a sin and a shame to expect them to carry all of the responsibilities put upon them by the law, when they are so inadequately compensated. Just the same, they should do the job in a workmanlike manner or let it go entirely.

Morbidity statistics are worthless unless used immediately and in the communities involved. For this reason the Bureau of Communicable Diseases is sending to each health officer a weekly report covering the preceding week. The location of the diseases will be indicated by counties. These reports are also being sent to all of the newspapers of the state and shortly will be sent to the libraries to be placed on bulletin boards. It will be well for the people to be on the alert for diseases which are prevalent in their own or adjoining counties. Under the new regime at the Division of Public Health, a great improvement has been noted in the reporting of communicable diseases throughout the state. Previous to last April the number of reports coming in was usually under three hundred. Recently most of the weeks have shown about three hundred seventy-five, and last week there were four hundred eleven reports submitted. There are four hundred fifty-two health officers who are supposed to report.

Reporting of infectious diseases is the very heart of all public health work. Don't put your county in the position of a certain county a year or so ago. It had three diphtheria deaths and not a single reported case. Evidently something was wrong in that county. Maybe that was the reason for three deaths from a strictly preventable disease in a very small county.

THE INDIANA PLAN

At a recent meeting of the county society secretaries, in Indianapolis, detailed explanations were offered by those now in charge of the Indiana Division of Public Health regarding various phases of the work, but more especially in the matter of health propaganda in the various counties. It was made clear that the county societies have had their work cut out for the future and it now remains to be seen just how well they will function.

The major objections to the program of the former board was that there was too much cutting in on the rights and privileges of the medical profession and that the program smacked strongly of state medicine. This was especially true in the Department of Child Welfare, which department had a sizable appropriation and bid fair materially to disturb many of our members who were

already viewing with alarm the rapid inroads it was making on their work.

Now that that is out of the picture, it remains for the profession to offer a proper substitute; we must not allow the matter of proper health propaganda to lapse; in fact, we must increase our activities in that direction. As one of the speakers said, "the present set-up in the Indiana State Board of Health is the greatest blow state medicine has ever had in Indiana." A criticism made was to the effect that "the Indiana State Board of Health has been turned over to the medical profession!" Well, for the love of something or other, to whom should it have been turned over!

Our work is before us and there is much of it to be done. As we have said, the component societies will have to bear the brunt of the load; to them we must look for the carrying on of the teaching of health and hygiene. Speakers must be furnished for all sorts of lay audiences and the greater part of these speakers must come from the ranks of the county societies.

It is unfortunate that every member of the State Association did not hear all the talks made at the conference, and particularly that of Dr. Thurman Rice, who gave detailed and minute directions on how to address a lay audience. Dr. Rice made it quite clear that impromptu health talks are usually not as they should be and gave a wholesome bit of advice when he said, "Don't start by saying that you haven't very much to say; if you have very little to say, say nothing."

One of our larger societies for some years has had what is called an educational committee. This committee has advised various organizations that the society will be glad to furnish speakers on any subject connected with health or hygiene. Their work has long since received the unqualified approval of the Association's Publicity Committee, and they are now devising ways to increase their activities in view of the plan adopted by the State Board of Health.

It should be borne in mind that in cases where other than a local speaker seems desirable the Board of Health will be glad to furnish such a program; there is quite an array of talent in the organization. We would urge all active county societies to appoint a committee to look after this work and that committee should notify all civic organizations within the territory that such programs are available. It is surprising how often requests are made for speakers, once the public is made aware that such programs are available.

We have long complained about the encroachment of state medicine in our domain; we now have a golden opportunity utterly to stamp it out. Let us do all in our power to support the group now in charge of our State Board of Health.

"CANCER CURES AND TREATMENTS"

Dr. Arthur J. Cramp, Director of the Bureau of Investigation of the American Medical Association, directs attention to the new edition of the brochure issued by his department under date of June, 1933. This little booklet has long been considered authoritative in the matter of exposures of the various advertised "cancer cures" and the new edition will prove of additional interest; it may be had for the nominal sum of fifteen cents from American Medical Association headquarters. The pamphlet deals with some thirty-nine "cures" or "treatments," most of which had more or less followers for varying periods of time.

The foreword to the new edition carries a very interesting comment. "It is to be borne in mind that a person with cancer will die just as surely by relying on an honest but misguided enthusiast as by submitting to the malpractice of the most blatant of cancer cure swindlers." The booklet is written in an interesting style and should be in the hands of all physicians who commonly see cancer cases of various sorts.

Our own Indiana has in times past been the seat of many of the most notorious cancer fakers in the country, though at the present time there are comparatively few in open operation. As intimated by Dr. Cramp, not all operators of these "clinics" are swindlers, that is in the sense of being in business for the sole purpose of swindling their victims; rather often one is found who really believes he has a certain cure of the dread disease. A few years ago, as a member of the State Board of Medical Registration and Examination, we were very much interested in an example of this sort. A young woman from the southern part of Indiana had communicated with the Board, seeking licensure. Apparently her inquiry was such that the routine information was supplied and she appeared at a subsequent meeting of the Board to make a personal appeal for a license to use her "cancer cure." Uneducated, so far as "book learning" goes, she possessed a marked ability to make known her wants. She did not want to practice general medicine, she wanted to treat nothing but cancer cases; she averred that she did not want to violate the law, and therefore wanted a special license. We recall the kindly questioning of Dr. W. A. Spurgeon, then the president of the Board; he inquired as to how she came to discover the treatment she proposed using. In her naïve manner she explained that it had come to her through Nature; that she had always been out in the woods and down among the hills of her home county, and that God had given her directions to use this bark, that herb and a certain root which, properly prepared into a certain form, had universally proved to be a cure for cancer.

The other side of the picture—this also a "character" in southern Indiana—was a retired blacksmith who had in some manner acquired a smattering of medical lore. He told that he had had one "course of lectures" in a medical school and did a thriving business in the coal mining section in which he lived. He was arrested and convicted

several times but immediately returned to his practice. This man, unlike the other case cited, was not unmindful of the financial rewards of his illegal practice and is said to have accumulated a considerable estate ere he died.

Then we had the "cancer hospital," of the type operated for some years in Indianapolis by the Leach, McNeil, Root outfit. This was finally closed, due to the untiring efforts of Tom Overley, of the Indianapolis Better Business Bureau. The hearing in this case, before the State Medical Board, resulted in the revocation of the license of Dr. Charles C. Root, which act seems to have had a most deterrent effect on similar cancer quacks.

All of this leads to the observation that now, when the public is more than commonly cancer-conscious, when the medical profession is more than usually active in the preachment of the gospel of the early recognition and early treatment of cancer, we should not overlook the fact that the public is seeking advice much earlier than formerly and it so happens that "advice" from cancer fakers is easily obtainable. We recommend having this little brochure handy about the office so that it may be given to patients who seem interested in some of these parasites who prey upon the gullible.

POSTGRADUATE COURSE HIGHLY SUCCESSFUL

The Postgraduate Course given by the Indiana University School of Medicine completed its final week on July 8th, 1933. The course was greeted by an enthusiastic response by the profession throughout the state. Considering that this is the first year such a comprehensive course has been offered, and in spite of numerous recent medical meetings, the enrollment of seventy-three postgraduate students justifies the continuation of such a course in the future. After the first week, which was given almost entirely to prescribed lectures, thirty-five remained for the elective work of the second week. The course reached at least sixty-five counties in the state.

One hundred and fourteen subjects were covered during the first week without any tardiness or absence of the speakers. The subjects throughout the day were covered by lectures, clinics and demonstrations, while the evening hours were given over to guest speakers as well as members of the faculty. The feature of the first day was the meeting and dinner attended by sixty-five secretaries of county medical societies. The relationship of the State Board of Health to the county societies was explained by Dr. John H. Hare, of Evansville.

Homecoming Night started with a dinner at the Riley Hospital, at which the speakers of the evening were guests of honor. Dr. Kenneth Smithburn ('28) of the biology and physiology department of the Rockefeller Institute of New York, spoke on "Experimental Immunity to Tuberculosis." Dr. Edward Billings ('28) of the Phipps Institute of Johns Hopkins, gave an address on "Psychobiological Evaluation of the Patient's Physical Symptoms." Dr. Frank Mann ('13) Professor of Experimental Surgery at the Mayo Foundation, concluded the evening with a dissertation on "Functions of the Liver."

Other evening addresses included Professor Frank H. Streightoff of Indiana University on "Savings and Investment"; Mr. Charles R. Beckett on "The Mathematical Basis of Life Insurance"; and Professor D. S. Robinson of Indiana University on "Medical Ethics." A talk by Dr. W. C. Alvarez of the Mayo Clinic on "Why People Break Down" was the chief event of the closing evening.

The second week of the course was entirely elective. Those who remained for this work found it most interesting and profitable as they were able to devote their entire time to clinical and experimental study of their own selection. Specially designed courses in medicine, surgery (both clinical and experimental), and obstetrics, had the best attendance. These courses were altered to meet the desires of those enrolled but some preferred ward walks, others experimental surgery, while still others attended wet clinics in the operating rooms. Medical, surgical and obstetrical seminars occupied three evenings of this week.

The prevailing opinion expressed by those attending the course was that the meetings compared more than favorably with postgraduate work in other medical centers. The necessity for such a course available to Indiana physicians has long been felt. Plans for enlargement and perfection of a similar course next May are already being formulated and it is hoped that many more physicians will avail themselves of the opportunity offered.

EDITORIAL NOTES

Dear Doctor:

The Journal and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital.

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Perhaps you want a certain kind of instrument which is not advertised in The Journal, and do not know where to secure it; this Service Bureau will give you the information.

Whenever possible, the goods will be advertised in our pages; but if they are not, we urge you to ask The Journal about them, or write direct to the Cooperative Medical Advertising Bureau, 535 N. Dearborn St., Chicago, Illinois.

We want The Journal to serve *you*.

We need YOU at French Lick in September.

Come to French Lick! Accommodations to fit every purse are available.

ONE of the newer druggists of Hammond believes in sticking to his trade; in choosing his telephone number he selected 606!

THE French Lick Springs Hotel still has a number of rooms which may be had for five dollars per day. Rooms at smaller hotels and in private homes are available. Rates are given on page 390.

THE appointment of Dr. V. K. Harvey to the secretaryship of the Indiana State Board of Health will meet with the approval of all who are familiar with his work as epidemiologist. Many of us had hoped that Dr. Hare would continue in that position, since we knew more about him and his work in similar lines, but he has elected to go elsewhere. With the appointment of Dr. Harvey we feel secure in the belief that the affairs of the board are in good hands.

DR. JOHN H. HARE, until recently secretary and executive officer of the Indiana State Board of Health, has resigned that position and taken over the superintendency of the Evansville State Hospital for the Insane. It seems that a reorganization was desired at the hospital, and we know of no one better qualified for that task than "Bunny" Hare. We are confident that under his management the Evansville hospital will be conducted in a manner much to the liking of the physicians of that part of Indiana.

HAVING just mailed a check for our Gross Income Tax, we feel that we have the right to comment on same. This tax thing has just about gone the limit, judging from the comments one hears on every hand. If, however, this form of tax will serve to reduce general taxation, and if it is not to be used in expansion of the various activities of the state, then we shall not have serious objection. However, we did take the precaution to send with our payment a formal protest of same, in the event the law is declared unconstitutional.

THE Indiana members of the House of Delegates of the American Medical Association deserve the highest praise from our members. Our personal observation at the Milwaukee session was that they were right up front in every matter that came before the house, were consulted liberally by those in authority and, in short, made an exceptionally good record, all of which supports the opinion that we long have had, that delegates should be continued in office from year to year. This year we had two new delegates, but the two older heads soon acclimated the neophytes and they were carrying on like veterans.

Northwest Medicine for July says, "As technocracy has captured the lay press of America, so has transurethral section of the prostate gland captured the urological periodicals." Not only has it captured the special journals but many of our state association mouthpieces are carrying such articles. A most interesting fact about this subject is that our own William N. Wishard in 1891 presented such a paper at a meeting of the American Association of Genito-Urinary Surgeons; the paper was published in *The Journal of Cutaneous and Genito-Urinary Diseases* in 1892. After all these years, the subject has become a live one and there are many claimants for priority in its origin.

THE financial report of the American Medical Association for the past year affords interesting reading and is worth studying a bit; if the *A. M. A. Journal* is not available, you will find a comprehensive abstract in *Time* magazine, for the latter part of June. Notwithstanding the depression, the activities of the Association showed a net profit of a little less than a hundred thousand dollars. One should bear in mind that certain of the publications of the A. M. A. are published at a net loss, yet they are deemed necessary, and in our opinion should be continued. Dr. West, Dr. Fishbein and Mr. Braun are to be congratulated on their showing for the year, a record that indicates they have built up a very successful organization.

OF ALL the foolish advice to appear from the pen of an editor of a medical publication (not a state journal), probably the most glaring specimen was noted in a recent issue. A physician had written to the editor, asking for a formula of some preparation to be used as a *local application for skin cancer!* Strange to say, the seeker for information was duly accommodated, for the editor gave him such a formula, together with directions for its use, stating that the formula had been obtained from a book entitled "1,000 Favorite Prescriptions." Not one word was said about the *proper* management of the condition; not one intimation was offered that various pastes should not be depended upon for help in any form of cancer. Page Dr. Bloodgood!

A GENTLEMAN from Missouri, in a recent letter to one of our exchanges, surely takes the hide right off when he briefly discusses the commonly used term, "What the doctor owes the community." His terse answer is, "The doctor doesn't owe the community a ———— thing!" Then he goes on to suggest that if *all* the doctors of this country were to take a thirty day vacation, at the same time, the people no doubt would awaken to the fact that they were missing a lot of good friends. We cannot ride the full way with the man from the "show me" state, but his letter does have a lot of common sense in it. We do, of course, owe something to the community in which we live, but it is our observation that the *average* physician has long since paid that debt and has a balance due him.

The House of Delegates of the American Medical Association is to be congratulated on naming Dr. Walter Bierring as president-elect. While there were other candidates nominated, each of whom is well qualified for the honored position, we must doff our hats to the accomplishments of Dr. Bierring. In addition to a busy professional career, he seems to have found time for innumerable activities connected with our profession, probably the most outstanding of which was his work with the Federation of State Medical Boards. For many years we had occasion to observe this particular activity and frankly say that no other man gave so unsparingly of his time and talents in furthering this important work. We are more than pleased that Dr. Bierring will be a guest speaker at the French Lick session, which is an additional incentive for a large attendance.

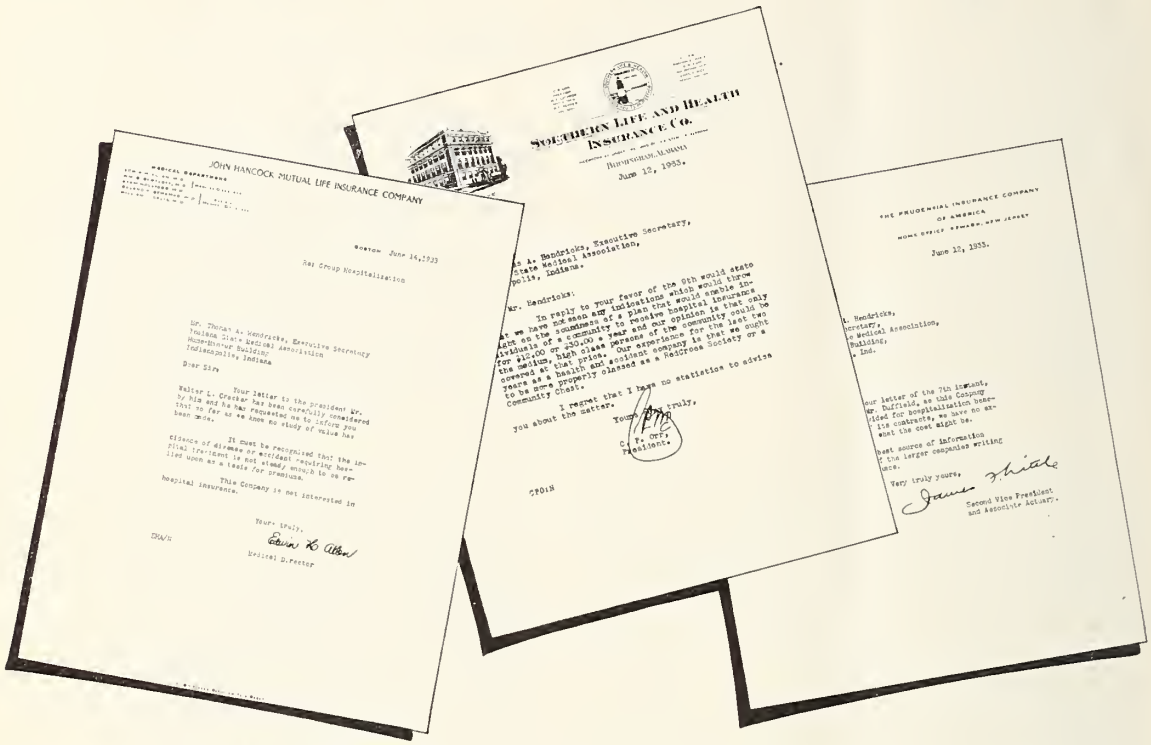
Good news for medical men, as well as others, lies in the observation that business is at last picking up; one needs but to scan the financial pages of our daily papers to confirm that observation. Here in the Calumet Region we are beginning to smile and whistle as we go about our daily chores, for on every hand there is evidence that "just around the corner" is fast becoming an expression of the *passé* sort. What with our steel mills operating at a capacity of more than 50 per cent, and the railroads calling back men who have not been regularly employed for as much as two of three years, we feel that we have seen the worst and that a few more months will find general business on the high road to recovery. However, this does not mean that we are going to collect all past due accounts in a short time; the average family has been so hard pressed and has acquired such an extensive list of creditors that it will be months and months ere their budgets even approach a balance; we will have to exercise our patience for some time to come.

"Business is picking up," seems to be the common experience these days; here in the great Calumet industrial region we find every evidence of this. Car loadings are increasing every day and the various railroads are putting on new crews for the first time in many months. As a result the medical profession soon will experience the pleasure of better collections, a thing we have been hoping for these many moons. In view of all this, may we ask if you have made your reservations for the French Lick meeting? You folks who for one reason or another have not had a vacation in some time, those who formerly attended our annual sessions but have not done so recently because of financial conditions, you are the ones who should make a special effort to run down to French Lick for a few days. A letter from Tom Taggart states that he will be there in person, standing on the front steps as you drive in, and that his sole job for the week is to see that the Hoosier doctors get the best that his tavern affords. Write Tom Taggart a letter today; tell him you are coming down; the more such letters he gets, the bigger the show he will put on.

Reading a lay publication, the other day, we came across an article written by the wife of a physician in which she said: "In discussion of the costs of medical care we frequently see the statement—'doctors charge too much.'" Then she went on to say that we *do* charge too much, not that our fees are too high but that we charge *too often.* The indictment lies against most of us; we do charge too often; folks come into our offices and carry out a little medicine; it does not amount to much but it is charged when a cash payment would involve no hardship on the patient. We daresay that we are no exception and we candidly admit that we have almost innumerable small charges that never will be paid; most of them would have been paid in cash had we but exercised even a mite of business acumen. Many minor repairs on glasses are done for nothing because of the fact that the bookkeeping and the billing of the patient for same are more than the little account is worth. The depression has taught us many things, one of them being that henceforth this charging business should be done on a different basis. Try it in your own office; it means you will have extra dollars in your pocket at the end of the month.

A short time ago we had something to say regarding the cause of so many malpractice suits; we commented on the fact that there is far too much "loose talk" by members of our profession regarding the work of confreres. Recently two cases were called to our attention, which bear out our contention that many of these pestiferous suits would not be instigated were it not for the untimely comments of some wiseacre. In one case a physician is charged with having made the overt statement, regarding the condition of an arm, that "whoever took care of this arm should be sued." Not only that, but this same man appeared as a witness for the plaintiff and his testimony is said to have been responsible for a rather large verdict. The second case, involving an alleged poor result from the treatment of an injury to an arm, terminated only when the attorney for the plaintiff was unable to find suitable medical testimony to bear out his contention of malpractice. It is rumored that the physician alleged to have "made" the case first cited will soon face a similar situation, in that he is to be made defendant in a suit; it will be interesting to note his attitude in the matter when he seeks supporting evidence to bolster his own case.

What Some Big Insurance Companies



By Thomas A. Hendricks

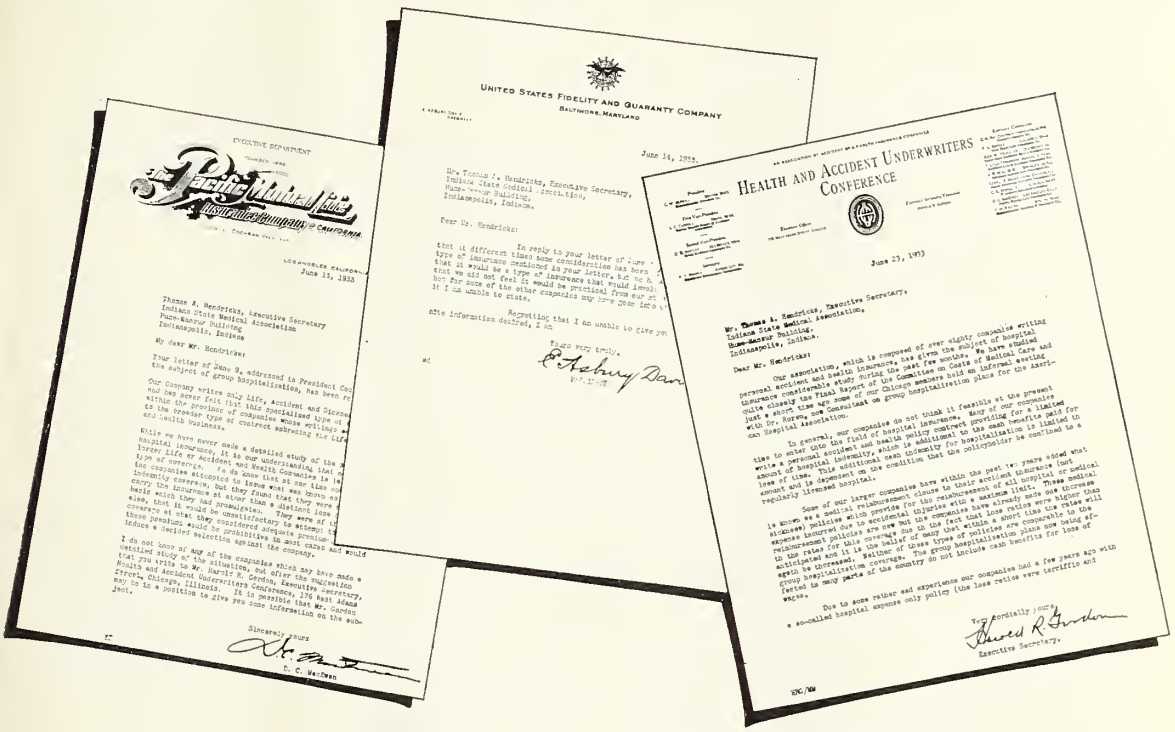
"STOP, Look, Listen" was the warning sent to the county medical societies by the officers of the Indiana State Medical Association last winter when schemes for group hospital insurance came so thick and fast that they almost snowed under the headquarters office. The result of this timely warning has been that despite many visitations from self-admitted group hospitalization experts, despite much oratory on the part of high-pressure salesmen offering hospital care to individual subscribers for as low as six dollars per year, no reputable hospital in Indiana so far as we know at headquarters office has "fallen" for the idea and no such plan yet has gained headway in Indiana.

Each plan presented has been considered carefully by the Executive Committee, the members of the committee have attended many meetings and listened attentively to the sponsors of these plans and in not a few instances have themselves discussed and criticized these projects in open meetings. They have read many articles and studied many a treatise, including the very carefully prepared and detailed studies advocating group hospitalization by the Council on Community Relations and Administrative Practice of the American Hospital Association, and the more recent brochure entitled "Hospital Care in the Family Budget" by C. Rufus Rorem, Ph.D., C.P.A., consultant on group hospitalization for the American Hospital Association, the principal spokesman for group hospitalization. Dr. Rorem (he is not a physician) is connected with the Julius Rosenwald Fund of Chicago and is said to advocate group hospital insurance plans under the direction of the backers of the Committee on Costs of Medical Care, whose majority report just didn't "click" with the public and despite showmanship, ballyhoo, publicity and even semi-governmental backing, now is almost as forgotten as the Wickersham report.

Just as in the case with the majority report of the Committee on the Costs of Medical Care, strenuous efforts are being made to high-pressure the profession into giving its "OK" to these various insurance plans. Some hospital superintendents here in Indiana enthusiastically advocate these plans and maintain that it not only is none of the business of the profession what the hospitals do, but that the hospitals sooner or later are going to undertake hospital insurance whether the physicians like it or not.

A marked characteristic of all these plans presented to date to the headquarters office of the State Association is a complete lack of any figures or statistics. The advocates all are sure that such a plan will work and point to several communities where they claim they are working, but for the most part these advocates are long on promises and short on actual figures. It is also noticeable that none of the larger insurance companies are among those advocating these plans. Naturally

Think of Group Hospital Insurance



the question arises as to what if any figures have been collected on the subject, what if any has been the experience of nationally known insurance companies with this kind of insurance, and, if these insurance plans are sound, why some of the major companies do not get into the field?

With this in mind, the following letter was written to ten of the major companies of the country:

"For the past several months many persons have advocated a partial payment plan to take care of hospital costs of patients. These various plans for group hospitalization have been put forth by organizations which are not nationally known. The feeling of the officers of the Indiana State Medical Association is that if such plans are worthwhile and economically sound, your company or some one of the larger insurance companies would have entered this field of insurance.

Has your company made any study or do you know of any studies that have been made by insurance companies which would throw light upon the soundness of such a plan which would enable individuals of a community to receive hospital insurance for from twelve to thirty dollars a year?"

As a matter of fact, this letter is most liberal, as in most of these schemes annual payments range from six to twelve dollars.

The answers are extremely interesting and although every answer should be studied separately, without exception there is nothing in any one of these letters from these major companies which would give one a basis to advocate such a scheme of insurance with confidence. Excerpts from these letters having to do with this subject follow:

June 14, 1933.

"It must be recognized that the incidence of disease or accident requiring hospital treatment is not steady enough to be relied upon as a basis for premiums. This company is not interested in hospital insurance."

EDWIN H. ALLEN, M. D., Medical Director,
John Hancock Mutual Life Insurance
Company, Boston.

June 13, 1933.

"I know of only one company that tried the kind of insurance to which you refer, and it was not, however, very successful. My recollection is that so many lawsuits arose out of the plan that it was abandoned."

————— —————, Second Vice-President
and Actuary, ———— Mutual Life Insurance Company, ————, ————.

(Preferred not to have name of company used.)

"While we have never made a detailed study of the subject of hospital insurance, it is our understanding that none of the larger life or accident and health companies is issuing this type of coverage. We do know that at one time one or two of the companies attempted to issue what was known as hospital indemnity coverage, but they found that they were not able to carry the insurance at other than a distinct loss on the cost basis which they had promulgated. They were of the opinion, also, that it would be unsatisfactory to attempt to sell the coverage at what they considered adequate premiums, because these premiums would be prohibitive in most cases."

D. C. MACEWEN,
Vice-President, The Pacific Mutual Life Ins. Co., Los Angeles, Cal.

". . . as this company has never provided for hospitalization benefits in any of its contracts we have no experience as to what the cost might be."

JAMES F. LITTLE,
Second Vice-President and Associate Actuary, Prudential Ins. Co., Newark, N. J.

". . . We have not seen any indications which would throw light on the soundness of a plan that would enable individuals of a community to receive hospital insurance for $12 or $30 a year, and our opinion is that only the medium, high class persons of a community could be covered at that price. Our experience for the last two years as a health and accident company is that we ought to be more properly classed as a Red Cross Society or a Community Chest."

C. P. ORR, President,
Southern Life and Health Insurance Company, Birmingham, Ala.

"Our company, although on various occasions has given considerable study and thought to the underwriting of an insurance plan of the type suggested in your letter, has never felt that the underwriting of such a pan of insurance would prove sound or satisfactory."

L. J. FROELICH,
District Group Supervisor, The Travelers, Pittsburgh, Pa.

". . . at different times some consideration has been given to the type of insurance mentioned in your letter, but we have always felt that it would be a type of insurance that would involve so much risk that we did not feel it would be practical from our standpoint."

E. ASBURY DAVIS,
President, U. S. Fidelity and Guaranty Company, Baltimore, Md.

". . . we have not made an exhaustive study of such plans but those that we have reviewed have not appealed to us particularly, either from a standpoint of public policy or benefit or as a matter of insurance coverage . . . it has appeared to me that there might be a very considerable selection against the hospital concerned in that the public were not entering as a whole or in a large group but in reality as individuals which provides an opportunity for those greatest in need of such service, from a physical standpoint, to obtain its benefits while those who may be less apt to need medical attention may not enter, thereby increasing the cost over that which might be sustained on the average were all to enter."

————, Medical Director,
A large established Accident and Indemnity Company.

THEN THE CLAIMS COME IN!

Dear Mr. Hendricks:

Our association, which is composed of over eighty companies writing personal accident and health insurance, has given the subject of hospital insurance considerable study during the past few months.

In general, our companies do not think it feasible at the present time to enter into the field of hospital insurance. Many of our companies write a personal accident and health policy contract providing for a limited amount of hospital indemnity, which is additional to the cash benefits paid for loss of time. This additional cash indemnity for hospitalization is limited in amount and is dependent on the condition that the policyholder be confined to a regularly licensed hospital.

Some of our member companies have within the past two years added what is known as a medical reimbursement clause to their accident insurance (not sickness) policies which provide for the reimbursement of all hospital or medical expense incurred due to accidental injuries with a maximum limit. These medical reimbursement policies are new, but the companies have already made one increase in the rates for this coverage due to the fact that loss ratios were higher than anticipated and it is the belief of many that within a short time the rates will again be increased. Neither of these types of policies is comparable to the group hospitalization coverage. The group hospitalization plans now being affected in many parts of the country do not include cash benefits for loss of wages.

Due to some rather sad experience our companies had a few years ago with a so-called hospital expense only policy (the loss ratios were terrific and the companies withdrew from the field) our companies are now reluctant to enter into this field again. The selection is against the company and if adequate premiums are charged for such coverage the policies are not salable.

It is entirely possible that a majority of the hospital plans now in effect will prove to be successful, due to the fact that more and more experience will be available as to what constitutes adequate premiums, and also due to the fact that the hospitals have a very vital interest in making these plans successful.

Two of our member companies have already entered into contracts with either hospital groups or medical groups for insurance of this type, but most of our companies prefer to wait until more adequate experience can be collected on the already existing hospital plans before entering this field.

In answering your inquiry as to whether $12.00 or $30.00 would be an adequate premium for group hospitalization coverage, I would have to know the indemnity provided and the restrictions or limitations placed on a contract before I could even estimate an accurate answer. I am informed that at the present time there is about a half day of hospitalization per insured risk per year and I believe the existing plans base their charges roughly on an expected loss ratio involving one whole day of hospital service per person per year. Personally, I doubt whether this is quite sufficient, as we in the accident and health insurance business know without any question that loss ratios increase tremendously on any new form of policy during the first four or five years. In other words, the average person with a new form of hospital policy does not become "insurance conscious" until he has had his policy a year or two—then the claims start to come in.

Very cordially yours,
(Signed) HAROLD R. GORDON,
Executive Secretary,
Health and Accident Underwriters Conference, Chicago.

THE PRESIDENT'S PAGE

The industrial control bill, which went into effect in July, has potentialities for the medical profession not realized by most of us. This act is but an indication of the social trend of the day. No less so is the new farm relief bill, or the home loan bill, or the public works bill, and much other legislation passed during the recent session of Congress.

The United States Chamber of Commerce, a strong political and financial organization of business men and manufacturers, for several years has opposed the encroaching paternalism of government, but this past few months they were forced to accept, and apparently like, government control of industry. This should make us stop and think seriously. If this experiment proves successful in industry, will not the government eventually extend its control into all lines of endeavor? If such an eventuality occurs that the medical profession be swept along with the general socialistic current, what preparation have we made that we may have a controlling voice in the operation?

Much is being said and written about "rugged individualism," the strength and bulwark of American success in the past, having had its day of usefulness, that it is now past, and that the only hope for the future lies in co-operation, controlled co-operation.

The strange thing is that so many conservative newspapers and magazines, in editorials and articles, have joined the ranks of the new social change, thereby moulding the destinies of many of the conservative individualists.

I do not believe that the practice of medicine can ever be a success from the standpoint of the laity, and am definitely convinced that it will be a failure from the physician's viewpoint should the physician be legislated into the socialistic practice of medicine. Individualism in the physician is a prerequisite.

Advancement of any science cannot be accomplished by prohibitory, inhibitory or compulsory legislation. Little or no advancement has ever been made under any of the above conditions. Rugged individualism and voluntary co-operation has done much to advance the world to the high standard of living and health of today, and the experiment of central control is a dangerous experiment.

Such an authority as Dean Donham of the Postgraduate Harvard School of Business Administration makes the following statement: "We are at the end of an era. The days of free and unlimited competition are gone. Whether we like it or not, domestic controls are going to be attempted. The option is no longer open for industry to control itself. But regardless of anyone's opinion as to the value of control, again I say, control is here."

In conversation with Dr. Olin West last year, I remarked upon the desirability of the medical profession having some plan to submit in event of the inevitability of government control of medicine. Dr. West refused to admit the possibility of the inevitability of such an event. And yet, who, one year ago, except with the possibility of a comparatively few theoretical dreamers, thought it possible that government would now be controlling industry?

I repeat that government control of the practice of medicine is doomed to ignominious failure as surely as the present Hospital Group Insurance plans are doomed to failure. The executive office publishes the report of an investigation in this issue; everyone should read and study it. Companies with decades of experience will not tackle the problem. No actuarial figures can be made for unpredictable liability and by unselected risks.

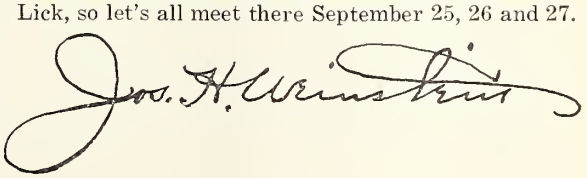
State Fair

The State Association is trying an experiment this year in line with the new health program. It will, in conjunction with the dentists, nurses, pharmacists and hospitals, have an educational exhibit at the state fair. This has been done in other states with great success, and the interest taken by the public in the educational exhibits put out by the American Medical Association, the American College of Surgeons, and other similar exhibitors at the Century of Progress gives us great encouragement that it will be well received and of great public good.

It will necessitate the sacrifice of time by quite a few physicians to help put it over. A committee composed of Drs. Sage, Sensenich, Graessle, Terrell and Wisener have charge, and when this committee asks your assistance for a half or a full day at Indianapolis, it is your duty to respond. We are now offered this opportunity to place scientific organized medicine before the public in a dignified way, so let's all of us do whatever may be requested of us to make the exhibit a success.

Annual Session

Next month is the annual session. A splendid program of practical scientific interest is arranged as well as plenty of time for entertainment and relaxation. All celebrities eventually visit French Lick, so let's all meet there September 25, 26 and 27.



ENTERTAINMENT AT FRENCH LICK

If you haven't already made your reservation for the French Lick session, do so now, for you will want to miss neither the fun nor the scientific meetings.

This year's session will be one big house party with a full program for everyone.

The golfers will have their annual luncheon on Monday, September twenty-fifth.

LADIES!

A special automobile trip to Spring Mill State Park will attract the attention of every convention visitor. You will not want to miss this unusual treat.

There will be a trap shoot for men at Dry Hollow, French Lick Springs Hotel. Are you a good shot?

A stag dinner with unique entertainment will be enjoyed Monday evening, September twenty-fifth. It will be served on the lower floor of the convention building, the French Lick Springs Hotel.

A theater party will be given Tuesday evening, September twenty-sixth, for the physicians and their wives, followed by a "general get-together" which will include informal dancing and bridge. Come to meet and visit with each other.

The Annual Banquet will be held Wednesday evening, September twenty-seventh, in the main dining room of the French Lick Springs Hotel.

The ladies will receive more than usual attention at this year's convention. There will be a dinner party with special entertainment and a reception at the French Lick Springs Hotel on Monday. A source of pleasure to all who attend will be the automobile trip through the beautiful hills of Southern Indiana to Spring Mill State Park, about six miles east of Mitchell, in Lawrence County. Spring Mill is a restored village of a century ago, with grist mill, apothecary shop, tavern, postoffice and log houses, hemmed in by a stone wall built as a protection against wild animals. 1,200 acres of land are included in the park. Donaldson's cave, said to have the largest direct opening of any known cave, may be seen in Spring Mill Park. The restoration of Spring Mill village meant the preservation of an actual living part of Indiana's pioneer life, and the portrayal of the conditions under which our forefathers lived. All guests at the convention will want to take advantage of this unusually fine opportunity. Tea will be served at the State Park Tavern.

Other entertainment has been provided and will be detailed in the September issue of THE JOURNAL.

The Woman's Auxiliary to the Indiana State Medical Association will have a breakfast and business meeting. Are you a member of your Auxiliary?

HOTEL RESERVATIONS.

Plenty of reservations may be had at the French Lick Springs Hotel at five dollars per day. Less expensive accommodations are available in other places. Make your reservations today.

Visiting ladies will be conducted through the Pluto Bottling Works of the French Lick Springs Hotel.

Golf, horseback riding and other forms of diversion will be available to those who enjoy sports.

The program will be published in detail in the September issue. Be sure to look it over carefully.

In addition to the French Lick Springs Hotel, the Homestead Hotel at West Baden and the Sullivan Hotel at West Baden will welcome guests. Rates at the Homestead Hotel are from $1.50 per day for single rooms to $5.00 per day for double rooms; at the Sullivan Hotel rates are from $1.00 per day for single rooms to $2.50 per day for double rooms. Small hotels and private homes offer rooms at French Lick at prices as low as one dollar per day. For reservations write to Dr. George Dillinger, French Lick.

TRAP SHOOT
AT
FRENCH LICK SESSION IN SEPTEMBER

All members of the State Association who will be interested in holding a shoot, please fill in the blank below and mail to Dr. George Dillinger, French Lick, Indiana.

Yes, I will be glad to participate in the Trap Shoot at the Annual Meeting.

.....M. D.

Address

Medical Economic Gleanings

The profession of our state must, for the protection of its patients and itself, become interested in state legislation, the State Medical Society, and in the annual state meeting.—*The Medical Bulletin*, Wichita, Kansas, June, 1933.

"There has been a great cry for economic planning. I often wonder whether the people who call for it really mean what they say. Are they willing to surrender their individual freedom to the extent necessary to co-operate in a plan. . . . Rugged individualism is not so bad, however much we jeer the phrase today."—Owen D. Young, quoted from *Time*, July 3, 1933.

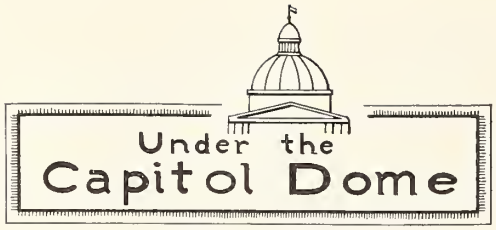
Awareness of Association activities should be the least that could be expected in the way of membership responsibility. Lack of this is a dangerously weakening factor; it is the cause of dissension and destructive, because unstudied, criticism of those delegated to the often thankless tasks of working for the profession as a whole.—Charles T. Sturgeon, M. D., *The Bulletin*, Los Angeles Co. Med. Assoc., June 15, 1933.

We must be in accord on the viewpoint from which any given problem in medical economics, affecting the profession as a whole, is approached. This viewpoint must be definitely fixed and adhered to in the discussion and mapping of programs of public relations activities. The question immediately is apparent: Shall the profession retain and protect individualism, or shall it retreat from this age-old stand in the face of demands for expediency measures?—*The Bulletin*, Los Angeles Co. Med. Assoc., June 15, 1933.

The immediate future of the practice of medicine is going to be greatly influenced by the character of state and national medical legislation. The osteopaths, the chiropractors, and practically all of the rest of the cults, as well as certain minority groups of so-called uplifters and reformers and also other groups with narrow and selfish individual benefits in mind, are becoming better and better organized and are directing more and more effort with increasing success toward the securing of the passage of many medical legislative measures which become increasingly detrimental to the medical welfare of the public and the regular medical profession.—*The Medical Bulletin*, Sedgwick County Medical Society, Wichita, Kansas, June, 1933.

For your information, I might tell you, gentlemen, that medical care per family per year costs in America $150.00—of which $37.00 is spent for patent medicines and drugs—the balance includes hospitalization, nursing, dentistry, and the physician's services, but the physician receives but $20.00 from this amount; while, on the other hand, the American family pays per year $674.00 for pure luxuries, many of which, from a medical standpoint, are detrimental to the public's health and could be dispensed with. In other words, the public appears to be very happy to spend $674.00 for pleasure but reluctant to spend $150.00 for medical care. It is argued that the medical drain on the financial resources is not so evenly distributed as these figures would tend to show but that it accumulates in selective family groups and assumes confiscatory proportions. Granting this to be true—there are still mighty few individual families whose medical bill approaches the average of the luxury bill quoted.—Seth A. Brumm, "Fundamentals in Medical Economics."—*The Medical Bulletin*, Wichita, Kansas, June, 1933.

We have heard a great deal within late years about the wonderful improvement that has been made in the medical service delivered to the run of people of Great Britain. I haven't the slightest doubt but that there has been a distinct improvement, because the system now in vogue, known as panel practice, is the successor to a system of voluntary insurance that was inefficient and unsatisfactory to an extreme degree. A few weeks ago I saw a distinguished gentleman who had recently been to England, where he saw panel practitioners in action. He described a scene in the surgery or office of one of them confronted with a group of patients. All patients who had cough were admitted in a group. No examinations were made, but some instructions, and perhaps some medicine, were given, and that group was discharged. Another group, presenting another symptom, was put through the same routine procedure. Through the continuation of that process of elimination all but two or three patients were disposed of; and since they did not present any very simple outstanding symptoms, they were given cursory examinations and sent—where? To the hospitals, where competent physicians were required to care for them without compensation for their services!!! And please bear in mind the very significant fact that the panel practitioner who did that to his patients was a man who had received fine training in good medical schools and hospitals! That, my friends, is sickness insurance as it works.—Olin West, M. D., from "A Discussion of the Reports of the Committee on the Costs of Medical Care," presented before the Tennessee State Medical Association, April, 1933.



A new three-man State Board of Health, to cooperate under the state government reorganization system, has been appointed. The members are Dr. Ernest Rupel, of Indianapolis, Dr. E. M. Van Buskirk, of Fort Wayne, and Dr. J. C. Glackman, of Rockport. All three men are members of their county medical societies and of the Indiana State Medical Association. The new board replaces the board which was composed of four members: Dr. Thomas W. Oberlin, Hammond; Dr. A. C. McDonald, Warsaw; Dr. John H. Hare, Evansville, and Dr. Frank W. Cregor, Indianapolis.

* * *

Hartford City has had ten cases of typhoid fever within the past month. A survey indicates that polluted streams and flood conditions were the cause.

* * *

Your State Department of Health safeguards the public health, and in particular it protects the water supply, thus materially lessening the toll of death throughout Indiana.

* * *

Physicians licensed through reciprocity since July 1, 1933, are: Gerald T. Watterson, Glenwood, Rush County, Indiana, from Michigan; Pieter Samsem, Anderson, Madison County, Indiana, from California; Frank Slater Jameson, Indianapolis, Marion County, Indiana, from New York.

* * *

The application of Dr. James K. Smith of Cincinnati, Ohio, to obtain a license to practice in Indiana was approved by the state board of medical registration and examination at its last meeting July eleventh. Dr. Smith will practice in Indianapolis, it was said at the board offices.

* * *

Dr. Ferguson (we were unable to learn his first name) of Chicago was denied an Indiana license because of the fact that this state has no reciprocal agreement with Illinois. Dr Ferguson, who plans to move to Fort Wayne to practice, will take the required medical examination soon.

Governor McNutt has reappointed tentatively all members of the old state medical board. They are serving at the will of the Governor. However, he has frequently said that he may be depended upon to co-operate to the fullest extent with the medical profession and with the Indiana State Medical Association.

* * *

An official communication has come from the secretary to the Governor to the effect that the members of the Indiana State Board of Medical Registration and Examination have all been re-appointed as of July 1, 1933. According to the letter, their terms of office are to be continued at the pleasure of the Governor and not to exceed his term of office.

* * *

For the week ending July fifteenth smallpox has reached the zero point for the first time in the history of the Bureau of Communicable Diseases, Indiana Division of Public Health. In comparison with records of previous years, the total of fourteen cases of typhoid fever is not alarming. Three cases of malaria were reported from rural districts of Crawford County.

* * *

Report of an epidemic of paratyphoid B in a section of Sullivan was made on July thirteenth by Dr. Thurman B. Rice, assistant director of the division of public health. He found that there had been nine cases of the disease, one resulting in the death of a nine months old baby. Unsanitary conditions, including city dumps, shallow wells, and untended outside toilets were blamed for the epidemic, which, Dr. Rice reported, is not likely to spread to the remainder of the city.

* * *

Improved sanitation methods in homes resulting from the untiring efforts of doctors has brought about the practical extermination of one of the formerly most prevalent household pests—the bed bug—according to Frank N. Wallace, state entomologist. A few years ago, the entomologist said, an average of 300 persons a month asked his department for a recipe for ridding their homes of bed bugs. Now the average is three a month. Mr. Wallace said that credit for extermination of the bed bug belongs to the physicians who have taught people the simple but all important rudiments of home sanitation.

A change in the attitude of persons asking advice on ridding their homes of the bugs also is noted by Mr. Wallace. "They used to whisper and seemed to consider the fact that the bugs were in their houses as a great disgrace," Mr. Wallace said. "Now they speak out quite clearly and seem to have the attitude that 'Well, we've got 'em, but I want the world to know we won't keep 'em.' "

SECRETARIES' COLUMN

The secretaries' conference, held at the Indiana University Medical School on June 26, 1933, was well attended, there being seventy-five present.

Dr. Gatch opened the meeting by stating the purpose for which it was called. Dr. Thurman Rice, Dr. John Hare, and Dr. Culbertson each gave a talk about the State Board of Health before the dinner. After dinner, Dr. Weinstein and Dr. Gatch gave talks about the State Board of Health and what had been accomplished.

I am sure that every secretary who attended this meeting knows all about the State Board of Health and the part that each county medical society secretary will play in this set-up.

It is up to the county medical societies to make this plan a success. This plan is for the physician in every respect. The Indiana Plan is being watched by all the states in the United States. If it succeeds, all medical societies in the United States will know that the doctors in Indiana are not asleep. If it wakes them up, we will have accomplished a great purpose.

Radio Advertising

I believe it is wrong for the people who advertise over the radio to say that "This is recommended by doctors," or "This is used by doctors," or "Ask your doctor." Almost 100 per cent of these articles would not be used by honest physicians. If they want to specify some one doctor who uses these articles, all right, but they should not say that we all use them.

Probably a letter to the presidents of the National Broadcasting and Columbia Broadcasting Companies would help correct this. I do not believe this is truthful advertising.

Caring for Indigent

How is the situation for the care of the indigent sick in your county? Keep plugging along on this problem and you will get some place.

If the doctors will work hard at the next election they can put in as township trustee anyone they want and then the situation will be helped greatly. If they do not do this, I do not see how they can make very much fuss about who or what the trustee is.

Post-Graduate Pediatrics

Do not forget that you can have post-graduate talks on pediatrics in your county society any time you want them by applying to the district chairman on Child Welfare.

A. M. Mitchell, M. D.

DIPHTHERIA REPORT FOR JUNE, 1933

We are very happy indeed to report that there were only two deaths from diphtheria in June, 1933. This is the least number for any month since January, 1930, with the exception of one. This brings the total number of deaths for the entire state for the first half of the year to fifty-four, which compares favorably with seventy-one for last year, fifty-seven in 1931, and fifty-six in 1930. If we keep steadily at the job there is a good chance that we may set the lowest rate ever made in Indiana.

It is extremely important that every case be reported during the next few months and that rigid precautions be taken against the spread of the disease in the early fall. Diphtheria begins in September and reaches its peak in October. Now is the time to prevent those cases and deaths. Immunization programs should be pushed to the limit.

Below will be found a tabulated summary showing the location of deaths for the first half of the present year:

County	Total for 1933	June, 1933
Allen	6	0
Bartholomew	1	0
Blackford	1	0
Daviess	2	0
Delaware	1	0
Dubois	1	0
Fulton	1	0
Greene	1	1
Hancock	2	1
Harrison	1	0
Howard	1	0
Jackson	2	0
Knox	1	0
Lake	2	0
Lawrence	2	0
Marion	8	0
Monroe	1	0
Morgan	1	0
Parke	1	0
Pike	1	0
Ripley	1	0
Shelby	2	0
Sullivan	3	0
Switzerland	1	0
Tippecanoe	3	0
Union	1	0
Vigo	1	0
Warrick	1	0
Warren	1	0
Wayne	1	0
Wells	1	0
Vanderburgh	1	0
	54	2

"VOICE OF THE DOCTOR"

THE POSTGRADUATE MEETING

JUST a word concerning the recent postgraduate medical meeting held in Richmond.

I wish to express my hearty approval of the plan which gives rise to this effort, and to express the hope that each year may afford us the opportunity to attend other like meetings. The symposium on the Endocrine persuaded me to look up some text book literature on this subject and I found Tice devotes 356 pages to the one gland, the pituitary. Even though we may not remember much of what was given us on that day, the stimulation to further reading is of inestimable value. As for me, I feel the Richmond meeting was well worth the time and effort, and I wish to thank all those who made the meeting possible and who were instrumental in executing so profitable a program.

EDGAR C. DENNY,
Milton, Indiana.

BABY SHOWS

July 14, 1933.

Dear Doctor:

In the Terre Haute *Tribune* for Tuesday, July eleventh, and the Terre Haute *Star* for Wednesday, July twelfth, appeared an article stating that the Modern Woodmen of America were putting on a baby show.

The Indiana State Board of Health has discontinued baby shows. The Indiana State Board of Health and the Indiana State Medical Association do not support baby shows. The State Board of Health will only put on programs for child welfare if asked to do so by the County Medical Society.

Since these baby shows are not sanctioned by the Indiana State Board of Health and since the Vigo County Medical Society has not been consulted in any way concerning this baby show, the officers of your Society request that you refuse to take any part in any way in this show.

Fraternally yours,

G. C. CONGLETON, President,
A. M. MITCHELL, Secretary-Treasurer,
Vigo County Medical Society.

(The above copy of a letter sent to members of the Vigo County Society is self-explanatory and may help other societies in formulating policies to cope with similar circumstances.)

DEATH NOTES

O. W. MCQUOWN, M. D., of Marion, died June twenty-third, aged fifty-six years. Dr. McQuown was health officer for Grant County and had practiced medicine in Marion since 1901. He served in the army during the World War. He graduated from the Medical College of Indiana, Indianapolis, in 1900, and was a member of the Grant County Medical Society, the Indiana State Medical Association and the American Medical Association.

FLETCHER D. NORTON, M. D., of Columbus, died June twenty-sixth, aged eighty years. Dr. Norton was a graduate of the Indiana Medical College, Indianapolis, in 1877.

JAMES H. NEFF, M. D., of Sullivan, died June twenty-first, after an illness of several weeks. Dr. Neff had served as county health commissioner for several years and as county coroner for two terms. He was a member of the Sullivan County Medical Society, the Indiana State Medical Association, and the American Medical Association. He graduated from the Kentucky School of Medicine, Louisville, in 1890.

COATNEY R. WALTERS, M. D., of Flat Rock, died June twentieth, aged fifty-four years. Dr. Walters graduated from the Medical College of Indiana, Indianapolis, in 1902.

GEORGE K. THROCKMORTON, M. D., of Lafayette, died July seventeenth, aged sixty-seven years. Dr. Throckmorton was widely known. He was a member of the Tippecanoe County Medical Society, the Indiana State Medical Association, and the American Medical Association; he was a Fellow of the American College of Surgeons. He graduated from Rush Medical College, Chicago, in 1887.

ROBERT L. MCCLURE, M. D., of Brownsburg, died July thirteenth, aged thirty-nine years. Dr. McClure graduated from the Indiana University School of Medicine, Bloomington and Indianapolis, in 1919.

WILLIAM RUHL, M. D., of Kimmel, died July fourteenth, aged seventy-seven years. Dr. Ruhl had retired from active practice. He graduated from the Fort Wayne Medical College in 1878.

HOOSIER NOTES

Mrs. Miles F. Porter, Sr., of Fort Wayne, died July seventeenth.

Dr. George H. Schlemmer has opened offices for the practice of medicine in Warsaw.

Dr. H. B. Stephens has moved from Dresden to Gleason where he will practice medicine.

Dr. and Mrs. Frank J. Kendrick have moved from LaGrange to Prophetsville, Illinois.

Dr. Lowell M. Green, of Rushville, has been made president of the Rushville Rotary Club.

Dr. M. E. Franz has located in Danville, where he will occupy the offices of the late Dr. Y. N. New.

Dr. S. R. Edwards, of South Bend, addressed members of the South Bend Rotary Club, July fifth.

Dr. Harold Brueckner, of Fort Wayne, has been appointed to the staff of the Irene Byron Sanatorium.

Dr. Thurman B. Rice, of Indianapolis, was a speaker at the Bedford Rotary Club, July thirteenth.

Dr. George Row, of Osgood, has been made a member of the medical staff at Culver Military Academy.

Dr. R. H. Richards has moved from Martinsville to Patricksburg where he will conduct a general practice.

Members of the Lawrence County Medical Society held their regular monthly meeting at Bedford, July fifth.

Twenty-two physicians attended the June thirteenth meeting of the Hamilton County Medical Society at Noblesville.

Miss Lucile Pierce, of Indianapolis, and Dr. Chris M. Cullnane, of Evansville, were married at Evansville, June twenty-eighth.

Dr. J. H. Crowder, of Sullivan, has been made county commissioner to fill the unexpired term of the late Dr. J. H. Neff.

Dr. Florence Olmsted has returned to Kokomo after an absence of eighteen months in the Rio Grande Valley of Texas.

Dr. D. L. Phipps, of Whiteland, celebrated his fortieth year in the practice of medicine at Whiteland, on June twenty-fourth.

Dr. Bruce A. Work, of Lafayette, has located in Frankfort, where he will occupy the office quarters of the late Dr. Charles Zinn.

Dr. George Collett, of Crawfordsville, has been appointed surgeon for the Monon Railroad, to succeed the late Dr. H. W. Sigmond.

The Eleventh District Medical Society will hold its annual meeting October eighteenth at Manchester College, North Manchester.

Dr. Werner Duemling, of Fort Wayne, was the principal speaker at the July thirteenth meeting of the Huntington Kiwanis Club.

Dr. Richard Schillinger, of Richmond, has been made superintendent of Easthaven, the Richmond State Hospital, to succeed Dr. L. F. Ross.

Dr. Matthew Winters, of Indianapolis, addressed members of the French Lick Kiwanis Club, July tenth. His subject was "The Underprivileged Child."

Dr. L. D. Holliday, of Fairmount, has been made health officer of Grant County to complete the unexpired term of the late Dr. O. W. McQuown.

Mrs. Ola May Dyar, wife of Dr. E. W. Dyar, of Ossian, died in a Fort Wayne hospital, June twenty-eighth. Mrs. Dyar had been ill for several years.

DR. GEORGE BEAMER, of Delphi, has been made a member of the city board of health to fill the vacancy created by the death of Dr. F. H. Robinson.

DR. R. H. STENGER, formerly on the staff of Easthaven Hospital at Richmond, has opened an office in Marion, where he will conduct a general medical practice.

A DINNER and golf tournament for members of the Madison County Medical Society and their wives was held at the Anderson Country Club, June twenty-first.

MISS NEDRA HILDEBRAND, daughter of Dr. W. O. Hildebrand, of Topeka, and Dr. F. Morse Nichols, of LaGrange, were married June twenty-fourth, in the Episcopal Chapel at Howe, Indiana.

MEMBERS of the Miami County Medical Society met at Peru, May twenty-sixth, in Dukes Hospital. Dr. Ernest Rupel, of Indianapolis, presented a paper on "Practical Urological Diagnosis."

MISS CLARA CATHERINE MEEK, of Noblesville, and Dr. Carl B. Southard, of Windfall, were married June twenty-sixth, at Noblesville. Dr. and Mrs. Southard will reside in Russiaville.

MEMBERS of the Hamilton County Medical Society met at Noblesville, June thirteenth, to hear Dr. Rollin Moser, of Indianapolis, present a paper. Attendance numbered twenty-four.

MISS MARY LOUISE FORT, of Marion, and Dr. Gilbert Schneider, of Evansville, were married June 2, 1933, at Portland. Dr. and Mrs. Schneider will make their home in Detroit.

"SOME Diagnostic Problems" was the subject of an address presented by Dr. J. H. P. Gauss, of Indianapolis, before members of the Jay County Medical Society at Portland, July seventh.

DR. BONNELL M. SOUDER, of Auburn, was a speaker on the program of the biennial convention of the National Federation of Business and Professional Women's Clubs in Chicago, July tenth.

DR. FRANK M. GASTINEAU, of Indianapolis, discussed "Some Recent Developments in Treatment of Skin Diseases" before the June sixteenth meeting of the Owen County Medical Society at Spencer.

DR. R. L. COMPTON, of Osgood, addressed members of the Dearborn-Ohio County Medical Society at Lawrenceburg, June twenty-ninth. His subject was "Public Health Administration Under the New Organization."

DR. T. E. WARD is remodeling a residence in Williamsport which will be used as a small hospital. Offices and operating rooms will be on the first floor, and second floor rooms will be patients' rooms. This is Warren County's first hospital.

MEMBERS of the Gibson County Medical Society had a dinner meeting at Wheeler's Cafeteria, in Princeton, July tenth. Dr. Pierce MacKenzie, of Evansville, presented an address, his subject being "Preventive Measures and Management of Eclampsia." Attendance numbered twenty-two.

DR. WALLACE GRAYSTON, Huntington surgeon, has been the object of an extortion plot and has received several threatening letters during past months. On June twenty-ninth a bomb consisting of forty-two sticks of dynamite was found in his garage. Police are making investigations.

THE American Congress of Physical Therapy will hold its twelfth annual scientific and clinical session September eleventh to fifteenth, at the Palmer House, Chicago. Preliminary programs may be obtained from the executive secretary, American Congress of Physical Therapy, 30 North Michigan Avenue, Chicago.

OFFICERS and trustees of the Indiana Hospital Association held a meeting on the lawn of the Cass County Hospital, at Logansport, July eighth, with 100 per cent attendance. The Indiana Hospital Association will co-operate with the Indiana State Medical Association and others in presenting an exhibit at the Indiana State Fair.

HAYFEVER frequency may be reduced in your own community through campaigns to eradicate ragweed from towns and cities and outlying regions. The U. S. Department of Agriculture has issued a pamphlet (95-L), "How to Control Ragweed." The Public Health Service has approved the suggestion in the pamphlet. It is estimated that 90 per cent of the cases in the fall, east of the Mississippi River, are caused by ragweed.

MEMBERS of the Tippecanoe County Medical Society met at the Romney Methodist Church, July thirteenth. A fried chicken dinner was served, after which a discussion of "Medical Organization" was presented. Speakers were Drs. J. H. Weinstein, E. E. Padgett, F. H. Jett, O. R. Spigler, F. S. Crockett, E. O. Nay, A. M. Mitchell, Alexander Cavins, and Mr. Thomas A. Hendricks. The plan of the State Committee for Child and Maternal Welfare was accepted.

In addition to the articles already enumerated, the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

Abbott Laboratories: Sterile Ampoules of Procaine Hydrochloride Crystals (Abbott), 100 mg. Sterile Ampoules of Procaine Hydrochloride Crystals (Abbott), 120 mg. Sterile Ampoules of Procaine Hydrochloride Crystals (Abbott), 150 mg. Sterile Ampoules of Procaine Hydrochloride Crystals (Abbott), 200 mg.

Lederle Laboratories, Inc.: Refined and Concentrated Antipneumococcic Serum, Type II (Lederle).

Eli Lilly & Co.: Extralin, Pulvules Extralin, 0.5 gm.

A MEETING of the officers of the Northern Tri-State Medical Association was held in Detroit, June eighteenth, for the purpose of planning the program for the 1934 annual meeting which will be held in Flint, Michigan. Dr. William Donald was host at the meeting which was held at the Detroit Boat Club. Officers who attended were: Dr. G. O. Larson, LaPorte, Indiana; Dr. G. E. Jones, Lima, Ohio; Dr. Norris Gillette, Toledo, Ohio; Dr. P. N. Sutherland, Angola, Indiana; Dr. W. H. Marshall, Flint, Michigan; Dr. William Donald, Detroit; Dr. H. E. Randall, Flint, Michigan; Dr. J. A. Dempster, Detroit; Dr. J. H. Andries, Detroit; Dr. B. F. Thut, Lima, Ohio; and Dr. E. B. Pedlow, Lima, Ohio.

A full day of postgraduate sessions and an evening program on child welfare will mark the annual meeting September thirteenth on the Indiana University campus, at Bloomington, of the Second District of the Indiana State Medical Association, according to the announcement of Dr. Ray Borland, president. The meeting will be held in the Chemistry auditorium on the campus with speakers of note in charge of the various clinics. An attendance of more than 100 is anticipated. Dr. Homer Woolery, Bloomington, is chairman of the program committee for the meeting, with Dr. Philip Holland and Dr. Russell DeMotte, also of Bloomington, assisting. Dr. Oscar N. Torian and Dr. Louis H. Segar, of the pediatrics department of the Indiana University School of Medicine at Indianapolis, will co-operate with the Bloomington committee in arranging the program. In addition to Dr. Borland, officers of the second district of the association are Dr. H. C. Wadsworth, Washington, councilor, and Dr. J. S. Brown, Carlyle, secretary. The postgraduate course in child welfare and maternity work to be held in connection with the association's annual meeting at Bloomington September thirteenth is part of the program of the state society under auspices of the Indiana University School of Medicine which has taken over this division of the State Health Department.

INDIANA UNIVERSITY NEWS NOTES

NINETY-SEVEN of the 104 graduates of the 1933 Indiana University School of Medicine have received appointments as internes in various hospitals throughout the United States, according to the announcement of Dean W. D. Gatch. The remaining seven doctors will either go into private practice at once or will accept an interneship later in the summer.

Sixty-eight of the young doctors will remain in Indiana, while 29 will serve their year of interneship in other states. Dr. Russell Lamb, of Amboy, will go to the Gorgas Hospital, Ancon, Panama Canal Zone. Of the 68 doctors who will do their hospital work in Indiana, 26 will be stationed at the City Hospital, Indianapolis; 17 at the Indiana University Hospitals, Indianapolis; 8 at the Methodist Hospital, Indianapolis; 7 at St. Vincent's Hospital, Indianapolis; 2 each at St. Elizabeth's Hospital, Lafayette; St. Joseph's Hospital, Fort Wayne; Lutheran Hospital, Fort Wayne; and 1 each at the Home Hospital, Lafayette; Epworth Hospital, Lafayette; Ball Memorial Hospital, Muncie; and St. Joseph's Hospital, South Bend.

Hospitals in other states at which more than one I. U. graduate will be stationed are the Columbus Hospital, Chicago; City Hospital, Cleveland, Ohio; U. S. Public Health, Chicago; and Harper Hospital, Detroit, Michigan. States other than Indiana in which young I. U. doctors of the 1933 class will be for their interne work are: Illinois, Ohio, Michigan, Wisconsin, New Jersey, Minnesota, California, Pennsylvania, Missouri, Nebraska, New York, and Panama Canal Zone.

The complete list is as follows:

Indianapolis City Hospital: A. L. Arnold, Wallace D. Buchanan, Ernest L. Dietl, David Dukes, H. N. Gladstone, William Green, C. H. Haggard, E. V. Harendeen, Charles Harrisk, John Hillery, Robert Howell, Kenneth K. Kraning, Dennis Megenhardt, Herbert Merillat, William Norman, Harry C. Peffer, Jr., George J. Petro, James Pfeifer, Thomas Possalt, R. Robert Richardson, Arthur J. Roser, Guy E. Ross, William Sandy, Victor Schriefer, William Sennett, John L. Sharo.

Indiana University Hospitals, Indianapolis: Eugene J. Alexander, Edith B. Schuman, Walter D.

Close, William Deutsch, Jr., Wayne Glock, Carl Harmon, Theodore R. Hayes, Ruth Hoetzer, William Kemp, James F. Lewis, Jr., James R. Reeves, Bernard Rosenak, Ethan Schreck, K. H. Stephens, Herbert F. Sudranski, Everett Thomas, Charles Webb.

Methodist Hospital, Indianapolis: Charles Grahame, Allen Hanna, David Jones, William Kelly, Jean Morris, Kenneth Thornburg, John Waller, Charles Wise.

St. Vincent's Hospital, Indianapolis: Charles Ade, M. M. McDowell, James Morrison, Floyd Napper, George Tennis, Edmund Van Buskirk, John Woner.

St. Elizabeth's Hospital, Lafayette: Avey Baker, William Matthew.

Columbus Hospital, Chicago: Thomas A. Cortese, Sol Finkelstein.

Cleveland (Ohio) City Hospital: Donald Covalt, Nils Kirkpatrick.

St. Joseph's Hospital, Fort Wayne: Floyd McCammon, Richard Miller.

United States Public Health, Chicago: Lee A. Dare, Francis Hodges.

Home Hospital, Lafayette: Lloyd Holladay.

Epworth Hospital: John R. Matthew.

Lutheran Hospital, Fort Wayne: John H. Gyer, J. D. Yoder.

Ball Memorial Hospital, Muncie: Helen M. Richards.

St. Joseph's Hospital, South Bend: Herman Rodin.

Harper Hospital, Detroit, Michigan: George Aitken, John S. Woolery.

Misericordia Hospital, Milwaukee, Wisconsin: Russell Baskett.

Mt. Sinai Hospital, Cleveland, Ohio: Robert Blondis.

Beth Israel Hospital, Newark, New Jersey: Paul Bornstein.

Fairview Hospital, Minneapolis, Minnesota: Martin Flem.

San Diego County Hospital, San Diego, California: George Held.

City Hospital, Akron, Ohio: Wayne Houser.

Hospital of the University of Pennsylvania, Philadelphia, Pennsylvania: Stephen Johnson.

Jewish Hospital, St. Louis, Missouri: Melvin Kirstein.

Gorgas Hospital, Ancon, Panama Canal Zone: Russell Lamb.

Nebraska Methodist Hospital, Omaha, Nebraska: Milton Miller.

St. Francis Hospital, Evanston, Illinois: Richard Nelsen.

Deaconess Hospital, Buffalo, New York: Wellington Reynolds.

Santa Barbara Cottage Hospital, Santa Barbara, California: Edgar Roehm.

University of Michigan Hospital, Ann Arbor, Michigan: Louis Schnute.

Provident Hospital, Detroit, Michigan: Gilbert Schneider.

Woman's Hospital, Cleveland, Ohio: Gertrude Stangle Stewart.

State of Wisconsin General Hospital, Madison, Wisconsin: John K. Stewart.

University Hospitals of Cleveland, Ohio: Paul Stier.

St. Lawrence Hospital, Lansing, Michigan: Roy Webb.

Lucas County Hospital, Toledo, Ohio: Bryce Weldy.

St. Vincent's Hospital, Toledo, Ohio: Frank Nichols.

DR. HOWARD WILLARD BYRN, of Terre Haute, was awarded the Ravdin Medal this year by the Indiana University School of Medicine. This medal is given each year to the senior who makes the highest average in the four-years' course for the M. D. degree.

SEVENTY-TWO physicians and surgeons enrolled for the intensive post-graduate course for doctors conducted June twenty-sixth to July eighth by the Indiana University School of Medicine at Indianapolis. Emphasis was placed on diagnosis and newer methods of treatment. A set program was arranged for the first week, while the program of the second week was optional and depended upon the subjects in which visiting doctors were most interested. Complete facilities of the three state hospitals and the other divisions of the Indiana University medical center were offered and the medical school dining hall was open to the visiting physicians.

A meeting of the county medical society secretaries and officers of the Indiana State Medical Association was held in conjunction with the course.

The list of prominent speakers for the post-graduate course included Dr. Frank Mann, who is in charge of the experimental laboratory of the Mayo Clinic; Dr. Edward Billings, member of the staff of the Johns Hopkins Medical School and a noted psychiatrist; and Dr. Kenneth C. Smithburn, member of the Rockefeller Institute, New York. All are graduates of the Indiana University Medical School.

The register of doctors attending the post-graduate course was as follows: William F. Allison, East Chicago; Fred H. Batman, Bloomington; R. A. Barker, Oakland, Illinois; G. H. Bowers, Fort Wayne; O. F. Brazelton, Princeton; C. W. Brown, Rolling Prairie; Charles H. Bruner, Greenfield; Raymond A. Butler, Beech Grove; Jasper Cain, Heltonville; S. M. Casey, Huntington; C. C. Collins, Roachdale; Edgar C. Denny, Milton; L. H. Eshelman, Marion; Wardlaw Ewell, Crawfordsville; Albert Faulkner, Waynetown; Frederick Greene, Bloomingdale; John H. Green, North Vernon; A. W. Hadley, Maywood; R. J. Harvey, Whitestown;

C. P. Hinchman, Geneva; W. R. Houston, Patriot; W. A. Laudeman, Elwood; C. D. Linton, Walkerton; Neal M. Loomis, Marion; Virgil McCarty, Princeton; R. B. McKeeman, Fort Wayne; W. Harold McKnight, Bedford; H. Allison Miller, Marion; Earl H. Morris, Princeton; Cecil O'Brien, Greencastle; E. M. Pitkin, Martinsville; Walter Portteus, Franklin; Gilbert Rhea, Greencastle; O. T. Scamahorn, Pittsboro; L. E. Somers, Decatur; E. A. Spohn, Walton; W. H. Terrell, Pittsboro; C. B. Thomas, Plainfield; Charles C. Wilson, Evansville; Paul H. Wilson, Logansport; Russell W. Wood, Oakland City; E. D. Wright, Seymour; Charles L. Badger, L. D. Bibler, E. E. Cahal, Samuel H. Caraway, Harold B. Cox, Glenn Conway, J. W. Denny, L. M. Dunning, E. T. Gaddy, John W. Graves, Frank Hall, E. L. Hays, Harry H. Heinrichs, Henry L. Hummons, J. W. Jackson, Jane M. Ketcham, James R. Lewis, R. E. Mitchell, Robert McKay, C. R. Marshall, Earl Mitchell, A. E. Mozingo, Portia Parker, L. R. Pearson, T. V. Petranoff, Alden Rarick, A. J. Schneider, W. Leland Sharp, M. H. Taylor, and H. S. Thurston, all of Indianapolis.

WOMAN'S AUXILIARY

Report of Convention, Women's Auxiliary to the American Medical Association, June, 1933

Milwaukee and its true hospitality will linger long in the minds and hearts of those who attended the American Medical Association convention. It is with gratitude and appreciation that we recall the many courtesies extended, the elaborate entertainment furnished, and the comforts provided. The many splendid entertainments, the thoroughness with which these arrangements were made, the outstanding musical talent, and the unusually artistic beauty that contributed to the success of these sight-seeing trips, garden tours, teas, luncheons, dinners, bridges, musicales and dances deserve mention.

The general Auxiliary meeting Tuesday was called to order by the president, Mrs. James F. Percy. After the invocation, a cordial address of welcome was given by Mrs. Fred Nause, Jr. In her response, Mrs. Southgate Leigh touched briefly upon the origin of the Auxiliary, and our chief objective, that of helping our husbands.

A tribute in memoriam to our late president, Mrs. Walter Jackson Freeman, was solemnly and beautifully conducted by Mrs. A. S. Kech, assisted by a vocalist with violin accompaniment.

Mrs. Percy stressed the importance of constructive work, overcoming cults and quackery through our influence in women's clubs and organizations, and always working under the guidance of our Advisory Council. She asked us to read the Auxiliary news letters in the Bulletins, that being the means of keeping in direct contact with Auxiliary affairs.

Fifty-one new Auxiliaries were reported to date, 1,551 new members, and a total of 13,688 members. The program chairman gave as a slogan "Know Your Auxiliary," and explained that this can best be done by reading and studying the Auxiliary Handbook. Thirty-two states have ordered Health Education material this year. Material will be sent upon request.

Chairman of Public Relations mentioned the value of this service as an organized force, and reported great development in the 34 states active in this work. Auxiliary literature has been distributed, more than 150 public relations meetings held, posters made, and speakers furnished lay groups.

A forward movement, more widespread understanding of fundamentals, and 31 states participating in the Hygeia movement reported.

Reports were given on Press and Publicity, Printing and Archives, and we were cautioned to "date everything." A suitable cabinet to house the files was requested. Record given of materials on hand. Secretary's, treasurer's and auditor's reports and proposed budget read. All reports accepted.

The Corinne Keen Freeman Memorial Fund was explained as that working fund established for use of incoming presidents.

Mrs. A. H. Brumback, Chicago, extended an invitation to visit the Auxiliary booth at the Century of Progress.

Increased interest, enthusiasm and activity in Auxiliary work, along its various channels, was reported by state presidents at the Wednesday morning session. Mrs. James Blake accepted the gavel and its responsibilities for the ensuing year, pledging to each state, county and member the loyalty of her head, heart and hand. Mrs. Robert Tomlinson, Delaware, was selected for president-elect.

The Auxiliary luncheon followed. Mrs. Percy, presiding, introduced Mrs. James H. Hackett, Wisconsin, toastmistress.

Dr. Dean Lewis, president of the American Medical Association, spoke briefly upon the outside interference with medical progress, such as objections to animal experimentation. Medicine, he said, should be run by doctors, not outsiders, and the Auxiliary is the organization to help the medical profession through proper advertising.

Dr. Edward H. Cary, retiring president, said the Auxiliary must understand the problems of medicine to be able to assist the profession. Its greatest assistance is that of influence through women's organizations, clubs, etc., in combating propaganda detrimental to the profession.

After paying tribute to our departed Mrs. Freeman and Dr. A. R. Mitchell, Dr. J. H. J. Upham voiced his appreciation of the Auxiliary, acknowledging its definite place in the medical field and the assistance it has rendered.

Dr. Eben J. Carey, Chicago, urged Auxiliary members to familiarize themselves with health education, then pass on this knowledge to others.

The beneficiaries of health education are doctors, dentists and pharmacists. The "Transparent Man" was used as a nucleus in his brief sketch of many of the educational exhibits from medical science at the Century of Progress.

At the Thursday morning session, in her suggestions for the coming year, Mrs. Blake stressed education, and asked that we consider carefully, honestly and unselfishly the problems of today and not underestimate importance of local units, inasmuch as national and state organizations are dependent upon the counties for success. Her instructions were: Use your Advisory Board. Have service to the men as your keynote. Back every health agency and worthwhile project, upon advice of your Advisory Board. Read your State Medical JOURNAL and learn the problems of your state. Keep the picture true to the color scheme. Fill all gaps. Watch for wasted effort. Lead in all things in which medical science plays a part. Keep your programs constructive and sound.

We are asked to study the constitution during this year, to be prepared at the next meeting to vote on changes. A plea to hold old members and get back the delinquents, by making meetings more interesting, was made by organization chairman. Only paid-up memberships are to be reported.

Mrs. McNab Miller brought to our attention the general co-operation between various medical societies and lay groups in Child Welfare service and the assistance rendered by Auxiliaries.

The "Question and Suggestion" box was opened, disclosing many helpful ideas.

The meeting adjourned until next year, at Cleveland. Let us all be there.

MRS. RANDOLPH L. COMPTON, Delegate.

BOOK REVIEWS

BOOKS RECEIVED

SURGICAL CLINICS OF NORTH AMERICA. Lahey Clinic Number, June, 1933. Volume 13, Number 3. 275 pages, with 98 illustrations. Per clinic year (February, 1933, to December, 1933), cloth $16.00; paper, $12.00. W. B. Saunders Company, Philadelphia and London, 1933.

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FRONTIERS OF MEDICINE. By Morris Fishbein, M. D., Editor, Journal of the American Medical Association. 207 pages. Cloth bound. Price $1.00. A Century of Progress Series, published by the Williams and Wilkins Company, Baltimore, in cooperation with the Century of Progress Exposition.

* * *

OBSTETRICS AND GYNECOLOGY. (Volume II.) By eighty leading specialists; edited by Arthur Hale Curtis, M. D., professor and head of the Department of Obstetrics and Gynecology. Northwestern University Medical School, Chicago. Complete in three volumes and separate desk index. 3500 pages with 1664 illustrations, many in colors. Cloth. $35.00 per set. W. B. Saunders Company, Philadelphia and London, 1933.

BOOK REVIEWS

INTERNATIONAL MEDICAL ANNUAL FOR 1933. A Year Book of Treatment and Practitioner's Index. Carey F. Coombs, M. D., and A. Rendle Short, M. D., editors. Fifty-first year. 572 pages, illustrated. Cloth. Price $6.00. William Wood and Company, Baltimore, publishers.

A manual that survives after a half century must suit the needs of the customers. The material covers advances in the diagnosis and treatment of many medical and surgical conditions, but the review of anesthesia, labor and its complications, and of thyroid surgery, are particularly good. Although the abstracts are from journals published in many lands, the English point of view is reflected. Truly, as the compiler remarks, every physician in active practice sees each year at least one case that could be better diagnosed or treated if he were aware of the advances recorded in the last two or three numbers of the Medical Annual.

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SURGICAL CLINICS OF NORTH AMERICA: Volume 13; number 11; New York Number. 523 pages. Per clinic year, paper binding, $12.00; cloth binding, $16.00. W. B. Saunders Company, Philadelphia and London, 1933.

Again the W. B. Saunders Company has brought out a valuable contribution to the literature on practical surgery. This volume is full of material of the most practical and readable kind. It might well be placed alongside the other volumes of its kind which have been produced.

* * *

EGG, WHEAT OR MILK-FREE DIETS, with Recipes and Food Lists. By Ray M. Balyeat, M. D., Oklahoma City. The J. B. Lippincott Company, Philadelphia.

To those interested in the management of the allergies and to those patients who have occasion to resort to certain restrictions in their diets, in connection with this manifestation, this book should be a god-send, since it solves some of the most perplexing problems of diet. The recipes given are good. The author is well known in the field of the allergies and in sending forth this volume has added to his laurels. The general arrangement of the book is exceptionally well done and the doctor or patient may turn directly to the information desired. The book serves a very definite purpose and serves it amazingly well.

* * *

MEDICAL STATE BOARD EXAMINATIONS. By Harold Rypins, M. D., Albany, New York. 420 pages, with index. The J. B. Lippincott Company, Philadelphia. Price $4.50.

Dr. Rypins, the author of this interesting and valuable book, is indeed well qualified to write such a treatise, since he has long been connected with the New York Board of Medical Examiners and his activity in the Federation of State Boards has given him opportunities to acquire an unusual knowledge of the subject.

We have long been accustomed to "Questions and Answers," this being in the form of a quiz compend, and quite familiar to many who have "faced the music" in State Board examinations. In this volume, however, we have a marked departure from the old form; this book is more of a review of the subjects usually covered in these examinations and should prove of much value to those brushing up for such tests.

It is exceptionally well indexed and, in general, is a volume of more than ordinary merit. We commend it to all interested in getting ready for such examinations.

* * *

SENILE CATARACT—Methods of Operating. By William A. Fisher, M. D., Chicago, in collaboration with Drs. Ernst Fuchs, I. Barraquer, H. T. Holland, J. W. Wright, A. Van Lint and O. B. Nugent. 267 pages, 182 illustrations, of which 112 are colored. Second edition. Published by Chicago E. E. N. and T. College, Chicago, 1933.

The second edition of this interesting book is now off the press; it shows many improvements over the first edition, many of the chapters having been rewritten and several new ones added. Chapter seven is of especial interest in that it outlines suggestions for improving one's technique, while another chapter is devoted to a discussion of prevention of accidents incident to this operation. It is but natural that the intra-capsular operation should receive much consideration, since it is the favorite procedure of the author, who seems to have made many advances in the handling of this type of operation. The entire book is very well done and should prove an interesting and very valuable acquisition to the ophthalmic library.

* * *

DISEASES OF THE EYE. By H. Ernst Fuchs, former Professor of Ophthalmology, University of Vienna. Fifteenth German edition, as revised by M. Salzmann; authorized translation by E. V. L. Brown, M. D., Professor of Ophthalmology, University of Chicago. Tenth English edition, with 255 illustrations and 41 colored plates. J. B. Lippincott Company, Philadelphia and London, 1933. Price $7.00.

This, the first English translation of the ophthalmolgist's "Bible" since the death of the late Dr. Alexander Duane, is somewhat of a disappointment in that there are numerous and rather glaring errors in the translation; certainly the reading text is not in the usual excellent language of Dr. Brown. As an instance of this we may cite the expression "a little *whiff* of cotton twisted on an applicator." The book abounds with similar errors, many of which tend to change the entire meaning of a sentence. However, to one who is a careful reader and does not become imbued with ennui in fathoming the meaning implied, the book continues to be the last word in ocular pathology. Certain chapters, particularly that relating to refraction, which have appeared in former editions, have been omitted in the present work. The concluding chapters, those having to do with the nerves of the eye, are especially informative and reflect the conceptions of this great teacher of ophthalmology. On the whole, while there are many disappointments in the book, it adds very materially to the library of the ophthalmologist.

SOCIETIES AND INSTITUTIONS

INDIANA STATE MEDICAL ASSOCIATION EXECUTIVE COMMITTEE

June 26, 1933.

Roll call showed the following present: W. H. Kennedy, M. D., chairman; H. H. Wheeler, M. D.; J. H. Weinstein, M. D.; O. O. Alexander, M. D.; E. E. Padgett, M. D.; A. F. Weyerbacher, M. D.; E. M. Shanklin, M.D.; Albert Stump, attorney, and T. A. Hendricks, executive secretary.

Guests: John H. Hare, M. D.; A. M. Mitchell, M. D., and C. N. Combs, M. D.

The monthly statements of receipts and expenditures in May and the report of the budget for May for the headquarters office and THE JOURNAL were shown.

Bill presented by chairman of one of the committees created by the House of Delegates at the 1932 annual meeting not allowed upon motion by Dr. Alexander, seconded by Dr. Weinstein, as no authority has been given the Executive Committee either by the Council or the House of Delegates to pay any bills incurred by this committee. The committee was of the opinion that this would set a precedent which it did not desire to establish of the Executive Committee authorizing payment of bills when it had not specifically been given the right to do so by the Budget Committee, the Council, or the House of Delegates.

Membership Report.

Number of members on May 31, 1933	2,481
Number of members on May 31, 1932	2,630
Loss over last year	149
Number of members on June 26, 1933	2,516
Number of members on June 26, 1932	2,653
Loss over last year	137
Number of members on December 31, 1932	2,723

Request for Refund of Dues by Mrs. S. M. Tilson, 742 Virginia Avenue, Indianapolis, Widow of S. M. Tilson, M. D., who died March 22, 1933.

The Executive Committee was of the opinion that as the State Association must defend the estate of Dr. Tilson for any malpractice cases that might be brought against it, no refund could be made of his State Association dues. However, a refund can be made for his JOURNAL subscription for three-quarters of the year.

Can Headquarters Office Receive Dues Direct from Individual Physician?

The opinion of Mr. Stump was requested by the Executive Committee as to whether or not, according to the Constitution and By-laws, a physician can send dues direct to the headquarters office instead of sending them to his county society secretary, and whether or not the headquarters office can send the card direct to the member without first being requested to do so by the county society secretary. Mr. Stump is of the opinion that this can be done without the secretary's request, but not without his approval. A formal opinion will be presented by Mr. Stump at the next meeting of the Executive Committee.

Post-graduate Meeting.

Letter from physician at Milton, Indiana, in regard to the post-graduate meeting brought to the attention of the Executive Committee. The Executive Committee suggested that this letter might be used in "The Voice of the Doctor."

1933 Convention, French Lick, September 25, 26 and 27.

Because of the fact that THE JOURNAL goes to press the first of the month, reports of all committees and officers should be in headquarters office by August 10 for publication in the September number of THE JOURNAL.

The committee was in accord with the action of the Editorial Board that the October number of THE JOURNAL should be held up a week in order that it may contain a complete report of the convention.

New form of program. After studying other forms of programs, the committee went on record approving the continuation of the printing of the program in its present form, both because of its attractiveness and its lower cost.

University Hospitals.

Report by the Public Relations Committee upon the use of rooms for private patients in the University Hospitals to be presented at next meeting of the Executive Committee.

What Is a Clinic?

Dr. O. O. Alexander to prepare material on this subject to be submitted to the editor of THE JOURNAL. Dr. Alexander cited the committee to the discussion of this subject by Dr. Dean Lewis, president of the American Medical Association, at the annual meeting of the Association in Milwaukee this month.

Group Hospitalization.

(1) Letters from insurance companies. A letter was sent to the heads of twelve of the leading insurance companies of the country. (This letter is printed on page 387 in this issue.)

Answers were received from the officials of most of these companies and without exception none of them recommended group hospital insurance as sound practice. The Executive Committee was in accord with the Editorial Board that an article containing excerpts from these letters be prepared for publication in the August number of THE JOURNAL, and copies of this article be distributed to the editors and the secretaries of the state societies and to the officers of the American Medical Association. Also, the Bureau of Publicity should prepare an article for release to the public press upon the article which appears in THE JOURNAL.

(2) Pamphlet received entitled, "Hospital Care in the Family Budget," by C. Rufus Rorem. This pamphlet was prepared by the American Hospital Association.

Presentation of Medical Viewpoint to the Public on Report of the Committee on the Costs of Medical Care.

The Executive Committee went on record to the effect that as the Committee on the Costs of Medical Care was making no undue headway with the public it would be better for the members of the profession not to discuss this matter in formal talks before lay luncheon clubs, service clubs, etc.

Cut of Fees by Insurance Companies.

The committee compliments Dr. I. E. Carlyle of Sedalia, secretary of the Clinton County Medical Society, for the courageous stand he took in his letter to the insurance company that asked him to cut his fee for making insurance examinations below the fee agreed upon by the Clinton County Medical Society.

State Board of Medical Registration and Examination Changes.

Dr. William R. Davidson resigns as secretary of the board and Dr. F. S. Crockett is elected by the board to succeed him. No further information in regard to the changes in the personnel of the State Board is known at this time.

State Fair Exhibit.

(1) The secretary reported upon the conference with E. R. Hays, M. D., head of the Nebraska State Fair Health Committee. This conference was held during the Milwaukee session of the American Medical Association. The consensus of opinion of the Indiana delegates who were present at the meeting is that a beginning in this work should be made this year by the Indiana State Medical Association.

(2) The Executive Committee went on record approving such an exhibit this year. This exhibit is to be made in a building set aside for the Indiana State Medical Association by the Fair Board.

(3) The following organizations are to be invited to have an exhibit in this building:

1. Indiana State Medical Association.
2. Indiana State Nurses' Association.
3. Indiana State Dental Association.
4. Indiana Pharmaceutical Association.
5. Indiana Hospital Association.
6. Indiana Tuberculosis Association.
7. American Medical Association.

(4) The following committee was appointed by Dr. Weinstein to take charge of this exhibit:

Russell Sage, Indianapolis, chairman.
R. L. Sensenich, South Bend.
J. E. Ferrell, Fortville.
H. P. Graessle, Seymour.
G. H. Wisener, Richmond.

(5) The Executive Committee set aside $150.00 as the maximum limit of expenditures for the Indiana State Medical Association for this exhibit.

Indigent Sick.

(1) Report made upon the conference with Fred Hoke, director of the State Relief Commission, and his assistant, William Book, in regard to the care of the indigent sick in Indiana. There seems to be a possibility that a part of any R. F. C. funds coming to Indiana for relief work may be used for medical purposes. As a result of the conference with Mr. Hoke and Mr. Book, the following general principles have been formulated and are to be presented to the relief commission with a view to having them adopted and promulgated by the State Relief Commission:

I. *Whenever possible the patient to receive the services of the physician of his own selection.*

During the present emergency we are dealing with persons who are not professional indigents and who in the past have been able to select and pay their own doctor. These persons should be allowed to select their own doctor instead of being forced to go to some township doctor, as their own doctor knows their family background and their social, economic and physical surroundings. His treatment of them should reasonably result in better care, with a resultant shortened and lessened morbidity. Keeping the patient with his accustomed family physician maintains a relationship which, when better times occur, makes it more natural and easy for the patient to resume payment of his own physician. This maintains the physician-patient relationship of normal times, and the patient will not be educated to receive free medical attention from a township doctor which will tend to force the habit of pauperism upon him. By employing a township doctor the immediate cost is small but the large number of patients treated by a township doctor makes actual professional attention difficult and tends to degenerate the services into routine medication. In the long view this may mean more severe morbidity later and increased expense. Permitting the sick person to call his own doctor will enable him to come out of the depression less accustomed to methods of pauperism and make it easier for him to resume paying his way later on.

II. *Relief Committee to issue instructions to its various district relief chairmen, advising them to deal with local county medical societies on the basis of a free selection of the doctor by the patient and upon a fee basis for services rendered.*

In entering into an agreement for medical care on a fee basis, the cost to the doctor for rendering this service should be taken into account, and provisions should be made whereby the local medical society should set up the machinery to make it impossible for any doctor participating to overcharge for his services. (A system of this sort has already been established in Kokomo.)

According to the report of the Committee on the Costs of Medical Care, the actual expense to a physician for rendering a service is between 40 and 45 per cent of the cost of that service. This covers operating costs alone to a physician and does not include home expense of a doctor. At present the trustee deals with the grocer, the coal operator, clothier and merchant on the basis of cost, plus a per cent, or is paying the regular price charged all customers. The medical profession does not ask preferential treatment but only equal consideration.

III. *The Executive Committee of the Indiana State Medical Association to hear questions of dispute between township trustees and the local medical society when these two groups cannot come to an agreement on proper fees.*

Thus questions involving medical fees may be brought by the local society to a neutral outside committee for consideration.

Post-graduate Assembly.

Report made that headway is being made in the plan whereby certain state societies should join together and put on a post-graduate assembly each year. This idea has been advocated several years by the Indiana State Medical Association.

Appointment of Committee to Co-operate with Pharmaceutical Association.

Dr. Weinstein attended the annual meeting of the Indiana Pharmaceutical Association at which time request was made that the Indiana State Medical Association appoint a committee to co-operate with the pharmaceutical association on matters of mutual interest. The Public Relations Committee was assigned this duty by Dr. Weinstein.

There being no further business, the meeting was adjourned.

INDIANA STATE BOARD OF HEALTH
BUREAU OF COMMUNICABLE DISEASES
Monthly Report, June, 1933

Current prevalence of the more common reportable diseases, as indicated by the reports of health officers and physicians of the state, shows a decline in all seasonal diseases such as measles, chicken-pox, scarlet fever, influenza, and pneumonia. However, a marked increase was noted in the incidence of typhoid fever and whooping cough.

A summary of the prevalence of diseases from the urban and rural areas for the month of June is given below:

Diseases	*Total*	*Urban*	*Rural*
Tuberculosis	130	43	87
Chicken-pox	192	120	72
Measles	587	469	118
Scarlet Fever	216	151	65
Smallpox	8	5	3
Typhoid Fever	69	28	41
Whooping Cough	325	195	130
Diphtheria	52	33	19
Influenza	81	15	66
Pneumonia	19	2	17
Mumps	96	56	40
Poliomyelitis	3	0	3
Meningitis	10	10	0

DIPHTHERIA. A slight decrease was shown in this disease as compared with the previous month, when 65 cases were reported. However, the total of 52 compares favorably with the corresponding month of last year, 61 cases being reported.

SCARLET FEVER. A good 50% decrease has been shown in the prevalence of scarlet fever. The reports for the past three years for the months of April, May and June indicate that there was an unusually large number of cases of this disease during the current year, but in view of the high percentage of decrease for the month of June, we do not consider there is cause for apprehension.

MEASLES is at a low ebb as compared with the period of the last seven years. The total of 587 for June represents a 50% decrease over the previous month, and compares favorably with the total of 586 reported for the corresponding month of 1932.

TYPHOID FEVER. Bicknell (Knox County) and Hartford City (Blackford County) both experienced epidemics of typhoid fever during the month of June. Dr. Harvey conducted an investigation at Bicknell and determined a polluted well to be the source of infection. Dr. Rice and Mr. Ellis made a study of the situation at Hartford City, and reported the trouble there to have started at the time of a flood during the latter part of May.

SMALLPOX. Considering the season of the year, a total of 8 cases of smallpox for the entire state is remarkably low. During the corresponding month of last year there were 47 cases reported.

MENINGOCOCCUS MENINGITIS. The total of 10 cases of meningocoecus meningitis during June occurred in Indianapolis. This total is identical with that for the previous month; however, in May the cases were widely scattered throughout the state.

One case of Rocky Mountain Spotted Fever occurred in Crawfordsville, Montgomery County. This is interesting due to the fact that in so far as our records are concerned, this is the first authentic reported case in Indiana. The diagnosis was made by a local physician. The laboratory of the Indiana Division of Public Health is prepared to make examinations which will assist in the diagnosis of Rocky Mountain Spotted Fever.

THURMAN B. RICE, M. D.

A total of 1,628 Indiana motorists were deprived of their driver's licenses during the fiscal year July 1, 1932, to July 1, 1933, according to Frank Finney, commissioner of licenses. Licenses of 1,388 drivers were suspended or revoked on conviction by courts, while 240 were suspended or revoked on citations by Gus Mueller, chief hearing judge in the license department.

Drunken driving resulted in 902 revocations or suspensions and was the cause of the largest number of actions against drivers. Reckless driving, speeding, and similar charges resulted in 437 suspensions or revocations.

ABSTRACTS

ATELECTASIS IN PULMONARY TUBERCULOSIS

BARNET P. STIVELMAN, New York (*Journal A. M. A.*, Nov. 12, 1932), concludes that: Acute lobar or multilobar atelectasis is rarely seen in pulmonary tuberculosis, but it may occur when a bronchus is plugged in the course of hemoptysis. Chronic lobar atelectasis may be seen in infants and children with tuberculous hilar adenopathy when the glands exert sufficient pressure on a bronchus to interfere with the normal pulmonary drainage. Chronic massive atelectasis in phthisis is usually confounded with extensive unilateral pleuropulmonary fibrosis. The patients usually have a benign course, although their sputum may often show the presence of tubercle bacilli. When respiratory distress develops as a result of the displaced mediastinal contents or when symptoms of activity supervene, patients with chronic massive tuberculous atelectasis can be effectively treated with induced pneumothorax. The pleura in such cases is usually free from extensive adhesions. Lobar or confluent lobular atelectasis is of the most frequent occurrence in all stages of pulmonary tuberculosis. The narrowing of the interspaces at the site of the lesion, the deviation of the mediastinum toward the lesion and the elevation of the homolateral portion of the diaphragm in early cases are due, not, as has been heretofore supposed, to fibrosis, which is of slow evolution, but to lobular atelectasis, which develops with great rapidity in any tuberculous pulmonary area. The great frequency of lobular or confluent lobular atelectasis in pulmonary tuberculosis appears to indicate that it is one of nature's ways of initiating fibrosis in the involved area. Lobar or multilobar atelectasis in the course of artificial pneumothorax is apparently a beneficial process and leads to a better collapse and early fibroses of the treated lung.

SYMPATHECTOMY FOR INTRACTABLE PAIN IN INOPERABLE CANCER OF CERVIX

According to J. P. Greenhill and H. E. Schmitz, Chicago (*Journal A. M. A.*, July 1, 1933), at present there are only two satisfactory ways of relieving the intractable pain that is associated with inoperable malignant tumors in the pelvis; both are surgical. One, cordotomy, requires an extensive laminectomy, and unless the incision in the cord is accurately placed the pain may not be completely relieved or paralysis may result. The second operation, sympathectomy, may readily be performed by any gynecologist. The risk involved is slight, the operation is technically not difficult, local infiltration may be used for at least part of the procedure, and the operation enables one to inspect and palpate the carcinomatous involvement. The operation that the authors advocate for the pain associated with inoperable carcinoma of the cervix consists of resection of that portion of the sympathetic system known as the superior hypogastric plexus or the presacral nerve and also the two hypogastric nerves. The results obtained in thirteen cases were remarkable because all the patients experienced instant and complete relief from their suffering. The authors believe this operation should be performed on almost all women who suffer constant and excruciating pain as the result of inoperative cancer of the cervix.

SURGICAL TREATMENT OF ARTERIAL EMBOLISM

Arthur A. Zierold, Minneapolis (*Journal A. M. A.*, July 1, 1933), reports a series of twenty cases of arterial embolism. With the exception of rare instances of detached atheromatous plaques, the larger animal parasites or artificially introduced foreign bodies, arterial emboli have their origin in cardiac thrombosis. The surgical treatment of arterial embolism con-

sists in the exposure of the affected vessel at the site of obstruction and the removal of the obstructing embolus and thrombus by arteriotomy. In his twenty cases the author performed this operation eleven times. The material here presented consists of eleven surgical cases and eight which were considered nonsurgical. In one case, which remains unclassified, the femoral vein was ligated and the artery was not opened. Although the procedure terminated successfully, it is not included in the operated group. Of the eleven patients operated on, only three survived. Of the eight patients who were not operated on, seven, or 87.5 per cent, died within a period of from one to fourteen days following the initial symptoms of embolism. The length of survival in the two groups was much the same, which gives some basis for the statement that surgery in itself is not responsible for the mortality in this form of treatment.

UNCONTROLLABLE CAUSES OF DEATH IN DIABETIC COMA

Herman Lande, New York (*Journal A. M. A.*, July 1, 1933), states that vital statistics for New York City show that the steadily rising death rate for diabetes has not been checked by the introduction of insulin. This increasing mortality is a still unsolved problem in which the increased incidence of diabetes and the associated vascular disease probably play major parts. He has undertaken an analysis of the cases of diabetic coma occurring in adults during the insulin period for the purpose of investigating this phase of the problem. In the insulin period from 1923 to 1933, eighty-two cases of diabetic coma were treated in the adult wards of the Mount Sinai Hospital. There have been twenty-four deaths, a mortality of 29 per cent. Two patients died in the early months of 1923 before an adequate supply of insulin was available. There were only ten fatal cases of uncomplicated diabetic coma. Eight cases were associated with conditions fatal in themselves. In this group, coma was of only secondary importance and its control had no effect on the outcome. The age incidence is of the utmost importance. This group does not include children under 14 years of age, yet the mortality of the forty-nine patients under 40 years is 12 per cent in contrast to that of 54 per cent in the thirty-three patients over this age. The author believes that these figures are significant, particularly as the vital statistics of the city of New York show that the introduction of insulin has favorably affected the diabetic mortality only in the group under 35 years of age. Two factors, shock and hyperprexia, are of importance in the mechanism of fatal diabetic coma. The vasomotor collapse or shock presents the problem of restoration of blood volume. In a certain number of elderly persons, the circulatory collapse may persist and death may result even after carbohydrate metabolism is proceeding normally and the ketosis has been overcome. In this particular group, insulin does not prevent a fatal issue and there is unavoidable mortality despite adequate treatment with insulin and fluids. In those who died of hyperprexia, the etiologic factor was determined only three times. There is the possibility that one is dealing, in the remaining seven cases, with a terminal blood invasion, but in view of the negative blood culture in one case, this phenomenon, when it occurs, must be regarded as an essential part of diabetic coma, perhaps as a concomitant of dehydration. This type of hyperprexia may be of cerebral origin. In the author's experience, insulin has proved ineffective in the presence of hyperprexia. This is an added source of unavoidable mortality.

NEUROSYPHILIS

Clinical reports indicate that forty to fifty per cent of cases of early paresis show symptomatic improvement under Tryparsamide therapy. The treatment does not disrupt the patient's daily routine of life and is available through the services of his personal physician. The cost of Tryparsamide has been reduced. The present price to physicians is, 1 Gm. ampul 40 cents; 2 Gm. ampul 55 cents; 3 Gm. ampul 70 cents. Clinical reports and treatment methods will be furnished on request.

Tryparsamide

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MERCK & CO. INC.
Rahway, N. J.

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ORIGINAL ARTICLES

"HOOSIER INCUNABULA"

THE EARLIEST MEDICAL PUBLICATIONS OF INDIANA AUTHORS

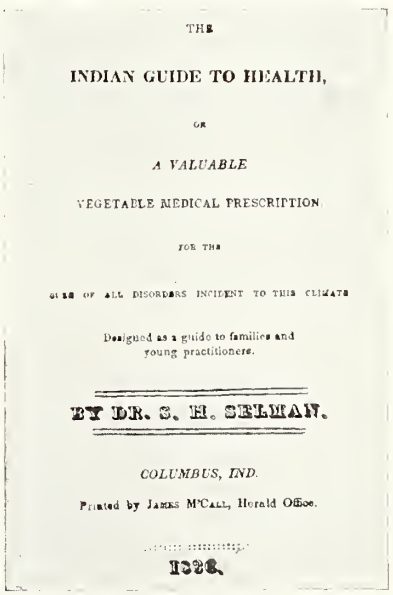
EDGAR F. KISER, M. D.*
Indianapolis

It seems strange that in this great commonwealth of ours, famous throughout the broad expanse of the United States as the home of distinguished literati, there has been such a dearth of medical literature. True, there have been numerous and excellent contributions to current medical journals, but the more operose and laborious undertaking, the writing of books, has evidently not appealed to many of our doctors, for medical texts from the pens of Indiana authors are few and far between. It is interesting to note, however, that some of our pioneers in medicine had the temerity to spread the gospel of healing through the medium of the written word, and it is a description of two of the very earliest of these medical texts—may I call them "Hoosier Incunabula"— that is the purpose of this article. Neither of the authors would be in the good graces of the council of his local medical society were he to publish today a work "Particularly Adapted to the Use of Heads of Families and Midwives" and even in that early period both authors excuse their dereliction on the ground of a thinly settled country and a scarcity of physicians. Both works are classical examples of the familiar "family physician."

The earliest is from the library of Doctor Leon G. Zerfas, through whose courtesy I am permitted to describe it. It is entitled "The Indian Guide to Health," by Dr. S. H. Selman, and was published in Columbus, Indiana, in 1836.

Dr. Selman's name does not appear in Kemper's "Medical History of Indiana," nor is he mentioned in Vonnegut's "Indianapolis Booksellers and Their Literary Back-ground." Neither is there any record of him in any of the standard histories of Indiana nor in the records of Bartholomew County on file in the State Library. I had almost despaired of finding anything concerning him when I learned of a notebook left by the late George Pence, one of the pioneers of Bartholomew County, to his local historical society. From it I quote verbatim, Mr. Pence's reminiscences of Dr. Selman:

"Dr. 'Squire H. Selman came from Kentucky, located in Columbus in 183—. Indian doctor, though a white man. Also Baptist preacher. Extensively patronized as a physician. Published small duodecimo volume, 'The Indian Doctor' or 'Guide to Health' of which he was the author.


THE

INDIAN GUIDE TO HEALTH,

OR

A VALUABLE

VEGETABLE MEDICAL PRESCRIPTION

FOR THE

CURE OF ALL DISORDERS INCIDENT TO THIS CLIMATE

Designed as a guide to families and young practitioners.

BY DR. S. H. SELMAN.

COLUMBUS, IND.

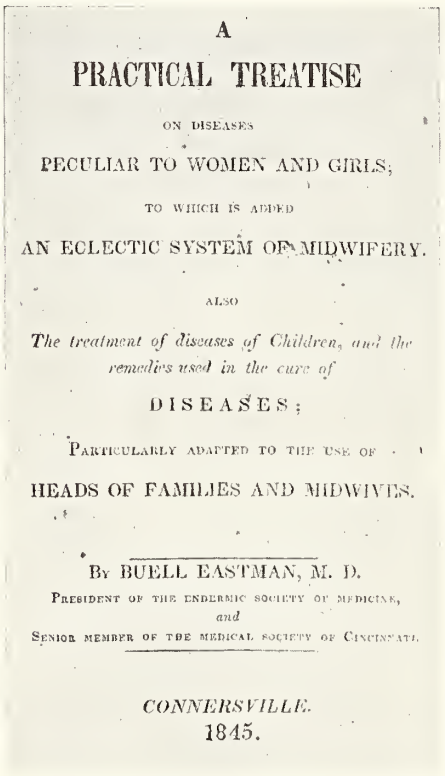
Printed by JAMES M'CALL, Herald Office.

1836.

Printed by James M'Call at Herald office and bound in Madison. Book sold at the high price of $1.50. The book described ordinary diseases of the Western country and set forth the kind of remedies to be used, and how they should be administered. He was a good-looking man of reserved and dignified demeanor and dressed with elegance and taste in the finest broadcloth. An elegant fob-chain and seal of gold and a watch of the same material—then very rarely worn in this section—adorned his person. By some mishap he had lost an eye,

* Assistant Professor of Medicine and Lecturer in Medical History, Indiana University School of Medicine.

but an artificial one filled the vacancy to all appearances as well as if it had been genuine. He was a man of some culture but judging from his book knew but little about medicine or surgery. He prepared his own remedies, having a small copper still and some retorts for that purpose. He made frequent visits to the woods, camping out Indian fashion for days at a time, with a party of helpers, gathering barks, roots, herbs, leaves and seeds, from which he extracted and compounded his medicines.



A

PRACTICAL TREATISE

ON DISEASES

PECULIAR TO WOMEN AND GIRLS;

TO WHICH IS ADDED

AN ECLECTIC SYSTEM OF MIDWIFERY.

ALSO

The treatment of diseases of Children, and the remedies used in the cure of

DISEASES;

PARTICULARLY ADAPTED TO THE USE OF

HEADS OF FAMILIES AND MIDWIVES.

BY BUELL EASTMAN, M. D.

PRESIDENT OF THE ENDERMIC SOCIETY OF MEDICINE,

and

SENIOR MEMBER OF THE MEDICAL SOCIETY OF CINCINNATI.

CONNERSVILLE.

1845.

"Fond of pets, he captured wild animals alive on his wood expeditions and brought back many a young fawn—once a black cub wolf. These he brought to his residence and soon domesticated. The wolf ran at large like a dog. In old age, however, it grew snappish. A pungent paragraph in the Herald respecting the wolf, gave great offense to the doctor. The animal, however, was still allowed its freedom and one day being found 'out of bounds' near Haw Creek, by two youngsters out hunting, it was shot and killed.

"Such was the doctor's fame and reputation that, though he charged high fees, he always had plenty of patrons. The mystery that attached to everything 'Indian,' the doctor's trips and encampments in the woods, his strange pets, the curious apparatus for extracting medicinal properties from vegetable substances, his reticence and gravity of manner, and the marvelous glass eye, doubtless contributed largely toward securing the extensive and profitable business with which he was favored.

"The regular doctors lost no opportunity to deride Doctor Selman's medical pretentions. He was by no means a 'sure cure' and without doubt shortened the days of many a poor, confiding patient. I remember one of his cases in which he was loudly accused of malpractice by the other doctors who described it about as follows: 'William, a son of Miles Bunnell, the tanner, was climbing a tree one day, carrying an ax to cut off a crooked limb for a sled runner, and accidentally cut his knee very badly. Selman attended him and the result was that the boy lost the use of his knee-joint entirely, but got well with a stiff and very crooked leg; that during the treatment the doctor applied a poultice or dressing of what he called "wet fire" which caused such intense pain the nurse was compelled to remove it; and that in throwing it out of the house it struck the door-frame and actually scorched it as with a red-hot iron.' Selman died in 1873 or the year following."

Dr. Zerfas' copy of Selman's book is a 16 mo. of two hundred pages, in contemporary calf. The paper is of poor quality, the printing fair, but the capitalization and punctuation would be a nightmare to a modern proof-reader. The copy is unfortunately badly stained, but is legible throughout. There is an index of diseases and remedies, not in alphabetic order, which includes herpes, tetter-worm, negro-poison, king's evil, "hooping" cough or chin cough, gravel and stone, and an extended discussion of mid-wifery.

Perhaps the best conception of the book may be conveyed by quoting a short chapter in full:

The Cramp Colic

"This is a colic that cramps the stomach, and draws the patient sometimes nearly double with violent pains all through the breast, and will roll through the bowels like goose eggs, and sometimes goes off with a lax, or discharge of wind up or down before the patient can get any ease. Parched peas eaten freely have had a happy effect, when other means have failed, a gill of dogwood berries boiled in a quart of water down to half a pint and drank, is wonderful; or boil a large burdoc leaf in a quart of water to a gill and drink; or take and scrape the inside of a pipe, soot water, or weak lye is very good, or take a teaspoonful of pulverized charcoal in a little water and drink this; or take a young shoat and cut it open in haste and obtain the gall and drink it and may probably relieve the patient; or make ginger tea and drink; or take calamus chew and swallow the spittle; or eat ginger root freely; or combine a small quantity of aloes, asofoetida, and rhubarb, put these in spirits and drink as needful; but of all medicines I have ever used is garlic boiled in new milk, this prescription often relieves the quickest of any remedy that has ever been tried. Beware

of eating such food as creates wind or is hard of digestion.

This disease is very bad,
And cramps the patient up;
And if a cure cannot be had,
You'll soon be drawn enough."

Mr. Pence comments particularly on Dr. Selman's elaborate stills and retorts. Imagine, if you can, the preparation of the following prescription in his primitive laboratory:

"To keep down inflammation, you will get one peck of green plantain, the same of liverwort, the same of winter-green, the same of burdock, the same of the blossoms of philadelphia fleabane, the same of poke-berries, the same of dogwood berries, you will put these ingredients together in a large kettle or still, boil them in fifteen gallons of water down to three gallons, then strain the liquid from the vegetables, add to the liquid two pounds of Epsomsalts, one pint of the tincture of gumguiacum, one quart of hard cider, half an ounce of the rust of iron, the same of salamoniac, you will now boil this down to one gallon, it is then fit for use; the patient may take from a teaspoonful to half a tablespoonful, three times a day, refraining from all strong diet."

It is a far cry from such a heterogeneous mess to the "elegant pharmaceuticals" of the present day. This has indeed been a "Century of Progress."

There is just one note of humor, unconscious of course, in Dr. Selman's book. Interpolated between the section on midwifery and that on therapeutics, and occupying an entire page, is the following evaluation of his students:

A List of My Students and Their Acquirements

"Thomas Selman, my brother, he was my first Student; he stayed with me three years and made great improvement in my practice.

"John E. Goodwin, stayed with me one year and made good improvement for the time.

"Silas D. Readish, he only stayed with me two or three months, he learned nothing.

"Napolian P. Young, another only studied with me a few weeks, he gained no insight.

"Samuel P. Langsdon, is the last student that has studied under me, he set in for two years, he has now been with me near eighteen months, his prospects appear very flattering."

Would we had the courage of our convictions today as men had a hundred years ago.

The second work which engages our attention is entitled "A Practical Treatise on Diseases Peculiar to Women and Girls, to which is added an Eclectic System of Midwifery" by Buell Eastman, M. D., published in Connersville in 1845. When I purchased the book, about two years ago, I had reason to believe that it was the first medical work published in the State of Indiana, and it was only three or four months ago that Dr. James Stygall called my attention to the Selman volume. Dr. G. W. H. Kemper, in the section on Medical History in Dunn's "Indiana and Indianans" shows the title page of the second edition of Eastman's book and says he believes it to be the first medical publication in the State. Of Doctor Eastman, we can learn but little. None of the State or Fayette County records mention him, Dr. W. N. Wishard has no knowledge of him, nor have any of a number of Connersville physicians or residents with whom I have spoken. Dr. J. Rilus Eastman is familiar with the name of Buell Eastman, but says that the family genealogy does not include him and Doctor Rilus believes that if there is a relationship, it is very remote. A brief note in the "Indianapolis Star" of March 12, 1919, concerning the copy of the book then in the possession of Dr. Kemper, said that Dr. Eastman came to Connersville in 1844 and was resident there for two years. I know of no way to substantiate the statement.

On the title page of his book, Dr. Eastman identifies himself as a "Senior Member of the Medical Society of Cincinnati." I wrote to Dr. Alfred Friedlander of Cincinnati for such information as he might be able to obtain for me and got the following reply: "I had our secretary go over the old records of the College. I find that Dr. Eastman was graduated from the Medical College of Ohio—the precursor of the present College of Medicine, University of Cincinnati—in 1832. The Faculty minutes read to the effect that when Mr. Eastman came up for final oral examination he did not pass. He was given a second examination shortly thereafter and at this time succeeded in satisfying the requirements of the examiners, and was accordingly given his degree in 1832. No further biographical data are available." It is my impression, however, that although Dr. Eastman "flunked his exams," he was rather a scholarly man, as a passage from his book, which I shall presently quote, will attest.

As to the book, it is a duodecimo of 182 pages, bound in hand-marbled boards. The paper, printing and composition are far superior to the Selman work and the pages are little discolored by age or use. Dr. Eastman evidently had faith in his brainchild, as the verso of the title-page carries an advertisement, giving the price of a single copy as $1.50; one hundred copies, $1.25 each; and five hundred copies, $1.00 each. That the work was a success is evidenced by the fact that Dr. Kemper's copy, which is now in the State Library, is the second edition.

The book is divided into five parts: The first is devoted to Diseases of Women and Girls; the second to Midwifery; the third to "Manual Labor"; the fourth to Diseases of Children; and the last to Medical Properties and Uses of Remedies.

Chapter One opens with a definition of puberty which is classic:

"Puberty is that period of life at which the person assumes its due proportions, and dis-

tinguishing beauty of form; the voice becomes more harmonious; the countenance more animated; and the motions more graceful. The sexual organs, which previously lay in a dormant state, are so far matured as to begin to exercise their functions. The bosom becomes greatly augmented; the breasts are expanded, and the nipple elongated. The womb and cavity of the pelvis are enlarged, and the menses appear. The future vigour of the constitution is greatly improved; and the sexual functions are now capable of full and active exercise and appear to be intimately connected with the spirits, energy and development of many parts of the oeconomy. The other functions undergo equally remarkable modifications, under the new and instinctive impulse which animates every part of animal life. The external senses attain fresh and peculiar activity; the intellectual faculties become greatly developed, while the moral and social manifestations show themselves in that indescribable feeling of interest, and captivating modesty and affection which characterize the female sex * * * Her mind is replete with changes; peurile amusements now yield to maturer enjoyments, and rational inquiry; capricious attachments give place to sincere unaffected and permanent friendship; and the best proportions the individual is susceptible of, are now suddenly and successfully developed, *in a word*, a new creature almost seems to be suddenly formed."

An appreciation of Eastman's intelligent conception of good obstetric practice may be gathered from his statement that "I hope to be credited when I declare, that more mischief is done, more misery and pain occasioned, and more broken and shattered constitutions are produced by the untimely interference of art, by handling and boring, and stretching the parts, than by all other things put together."

Nor was Dr. Eastman a polypharmacist. His book contains none of the shotgun mixtures which abound in Selman's work. In fact, his Materia Medica might not be a bad guide for a recent graduate. Read what he has to say of opium:

"Opium is one of the most valuable articles belonging to the science of medicine. Taken by a healthy person in a moderate dose, it increases the force, fullness, and frequency of the pulse, augments the temperature of the skin, invigorates the muscular system, quickens the senses, animates the spirits, and gives energy to the intellectual faculties. Its operations are extended to all parts of the system. In a short time this excitation subsides, a calmness of the corporeal actions, and a delightful placidity of mind succeed, and the individual, insensible to painful impressions, forgetting all sources of care and anxiety, is conscious of no other feeling than that of a quiet and vague enjoyment. All the secretions, with the exception of that from the skin, are either suspended or diminished, the regular motion of the bowels is arrested, pain and inordinate muscular contraction if present are allayed, and general nervous irritation is composed, if not entirely relieved * * * No medicine is so efficient in allaying nervous irritation, relaxing spasms and quieting irregular muscular movements, as this article. Hence its great importance as a remedy in cramp, spasms, colics, painful menstruation, hysterics, coughs, etc."

And so throughout Buell Eastman's book, every paragraph and every sentence couched in splendid English, we see a keen insight into the principles of medicine and obstetrics, crude as the practice must necessarily have been. It seems a pity that his talents were not turned to a worthier cause than the production of a popular guide to medicine. And yet, who can question his sincerity when, in his introduction he says: "The present work has not been undertaken without due deliberation upon the responsibility attached to such an enterprise."

I am reasonably certain that these two books, Selman's "Indian Guide" and Eastman's "Treatise" are the earliest medical works published in Indiana. However, if any of my readers can direct me to a work of earlier date, the information will be greatly appreciated.

I wish to acknowledge my obligation to Miss Esther McNitt of the Indiana State Library, to Mrs. Albert G. Newsom and Mrs. Roseada Pence Pruitt of Columbus, Indiana, and to Miss Caroline Dunn, Librarian of the Connersville Library, for their co-operation and help.

PSYCHOLOGICAL FACTORS IN MEDICINE*

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Psychiatry has been the Cinderella of the Medical Specialties. For years she sat alone by the fire in the kitchen, while her proud sisters, Ophthalmology and Pediatrics, strutted in the parlor. Sister Surgery was there, too, quite the queen of them all, forgetful of her humble origin in the barber-shop, and Mother Obstetrics was never reminded of her poor relations, the Midwives. When, by the Fairy Godmother's aid, the transformed Cinderella appeared at the Great Ball (the war), she outshone all her sisters. It was there she won the Prince's favour (popular esteem), and thereafter she came out of the kitchen and consorted with her fashionable and now deferential sisters, and at last married the Prince.

This allegory is peculiarly apt. It sketches the development of psychiatry from the sterile, stagnant "asylum" to the present unparalleled popularity of

* Presidential address delivered before the Indianapolis Medical Society, January 3, 1933.

a specialty which, because of its inclusiveness and its intimate relationship with all other branches of medicine, might even be considered the keystone of medical science.

The fairy godmother responsible for these great changes is a melioristic philosophy which kept alive the embers of hope in the hearts of the early psychiatrists, whose task was generally regarded as hideous and hopeless. The patients relegated to them were the mad, the moonstruck, the lunatic, the alien, the devil-possessed, the idiotic, the demented, the insane. The very words are hideous, and their origins and meanings indicate the prevailing sentiments of aversion with which those afflictions were held.

Such feelings of aversion emanated from:

1. The hopelessness ignorantly ascribed to such cases.
2. The helplessness of early medical science to understand or relieve them.
3. The persistence of superstitions and religious hypotheses dealing with their origin, their relation to sin, devils, evil spirits, and the like.

Of these, certainly the third has been the most powerful. Madness has for centuries been taboo—that is, both sacred and accursed. The taboo still attaching to it on the part of the rabble is betrayed by the archaic language of the law, but the progress of medical science and the extension of knowledge has lifted the taboo for the intelligent. The victims were found to be less hopeless than at first they seemed, and the increasing demands of civilization upon poor mortal frames increased their numbers. Familiarity replaced taboo with toleration and with the crusading spirit of modern preventive medicine.

Thus psychology and medical science were for centuries as far from each other as heaven is from earth. Psychology was considered by the practical mind of the physician as ideal philosophical wisdom, which was regarded with distant awe, but which could not possibly be of any earthly use in the affairs of ordinary medical practice. This relation is no longer maintained; the imperative necessity of treating mental diseases and the investigation of abnormal mental life in general, and the recent researches into the more complex nervous and mental troubles forced medical science into psychology. Psychiatry is not something apart from medicine. Psychiatry is one of the specialties of medicine, and as such is a biological as well as a social problem. The relationship between psychiatry and general medicine has experienced considerable growth especially during the last few years. It is, however, only within the last century that the practice of medicine has been severed from its connection with the black arts, witchcraft, astrology, phrenology, quackery, and knavery of all kinds; most of these are more or less psychological in their nature.

The medical man of the present day values too much his freedom from the errors and mysteries of medieval medicine not to look with a somewhat jealous eye upon anything that distracts from his physical studies. He knows too well what his profession owes to the inductive methods of diagnosis, to exact observation aided by modern instruments of precision, to the advances in physiology, pathology and bacteriology, to turn aside to the study of the interaction of the physical with the psychic. To talk of the patient's mental actions in a case of tuberculosis, when the bacillus swarms in the sputa, would seem to appear incomprehensible. What folly to speak of mind influences in typhoid fever, when the enteric ulcer can be seen on post mortem in the pathological area! We can catch and stain and double stain the microbes of many infectious diseases; what nonsense it seems, then, to talk of fear as a casual factor.

In urging some attention to the psychological factors in medicine I would not for one moment be thought to depreciate in any way the great and real advance in the art of medicine; nor to deny that it has undoubtedly been due to a steady persistence in exact scientific observation. The general physician often hesitates to deal with mental conditions, although he attacks with confidence problems of equally obscure organic, serologic or bacterial origin. For example, the clinician makes use of the technical researches of the specialist in cardio-renal disorders, or of the biochemist in diabetes, or of the endocrinologist in the use of complicated gland therapy. The interplay in the organism between mental and bodily factors is not always easy to recognize, and to recognize the more intricate relationships requires special study and a certain special aptitude. In the light of present-day research in physiology and psychopathology, the general physician should be able to bring to bear a working knowledge of the mental pathology which should enable him to attack confidently much of the mental disorder in his practice.

The general practitioner usually is the first to come in contact with the patient. It is extremely important that he be equipped to recognize symptoms of a mental character. Otherwise valuable time is often lost, while grave neural or mental disease is overlooked, or mistaken for a passing functional or simple organic disability. My purpose in this presentation is to direct attention to the significance of certain mental phenomena which commonly appear in general practice. I recall that in my student days we listened with rapt attention to the latest methods in asepsis, the culture of micro-organisms, the use of antitoxins, the study of the powers of various drugs; discussed keenly the rival merits of diverse forms of splints, sutures, forceps, inhalers, and various instruments of precision; we were carefully shown the best methods of physical diagnosis. All these necessary and important factors in therapeutics were thoroughly ex-

hausted, while at the same time the omnipresent mental factor was almost universally ignored. Though the influence of the mind over the body, as well as of mind over mind, is everywhere seen and felt, it is still greatly neglected and ignored in our out-patient departments, in hospital wards, in consultation rooms, and by sick-beds, and hence the amazing spectacle so constantly seen of men laboriously trained in all the medical wisdoms of the twentieth century patiently investigating the causes of disease, or earnestly considering methods of cure, without a thought of the ever-present mental factors; and sometimes hardly realizing that the case is that of a suffering human being, and not merely of a machine that is out of order.

There can be no doubt that, had the mental factors in medicine been recognized and studied by the profession, quackery would never have obtained the position it has in our day. The more the ranges of influence of the mind over the body in health and disease are narrowed, the more charlatanism flourishes and credits itself with cures really due to mental factors. I do not wish to be too pessimistic in tone, for we have reason to believe that medical practice is increasingly influenced by the conception that man is an organic whole, partly psychical, partly physical; not a mixture, but a compound of mind and matter.

Mind has been a phenomenon treated as detached from consideration by the laws applicable in other departments of medicine. In the search for explanation, in the growth of an interpretative psychiatry, in the change from the static to a dynamic viewpoint, the false distinction between mind and body has gradually given away to a method which no longer stresses this distinction but sees in the mind the personality make-up, the final expression of the total integration of the individual into an organic unity, and realizes for the first time that psychological mechanisms are at least analogous to those mechanisms with which medicine has so long been familiar in its other departments.

In psychiatry the student is for the first time introduced to a consideration of the organism as a whole, to its total as contrasted to its partial reaction. There is no reason why the internists may not also properly approach the problem of disease as it involves particular organs from the standpoint of the organism as a whole. The great difficulty with the internist has been that he does not take the personality into consideration. Now psychiatry, dealing essentially, as it does, with total reactions, that is reactions of the individual as a whole, which is only another way of saying mental states, is peculiarly in a position to rescue medicine as it were from its hopeless quest for adequate explanation in a consideration of anything short of a whole individual. The whole can never be explained by the parts. No search, no matter how painstaking, will ever discover an idea in the section of the brain tissue under the microscope. The great contribution which psychiatry has to make to medicine, therefore, is this emphasis upon the total reaction and which is largely the same thing, its emphasis upon the importance of studying the phenomena of consciousness and realizing that the understanding of the individual can not be accomplished by an approach that is wholly from without, so to speak, that is, that takes no cognizance of the situation from within. Happiness is at least as important a goal as a urine of a certain specific gravity.

Not only is it important in general for both psychiatry and general medicine to recognize and understand the nature of total reaction types of response, but it is of the greatest practical importance for the whole field of therapeutics, otherwise therapeutic agents, pharmacological, surgical, climatic, recreational or what not, are in constant and serious danger of being wrongly valued. The personality make-up cannot be safely kept out of consideration in any problem that affects the individual. It is obviously fundamental in psychiatry, it is less obviously but often equally fundamental in internal medicine, and it is often of the very first significance in therapeutics. Whole fields of therapeutic endeavor are constantly receiving their stimulus from successes almost if not quite wholly dependent upon psychological therapeutic values yet the results are as constantly attributed to agents employed, usually a drug or an operation. That such a serious distortion of what actually takes place is possible, not only spells danger for the patient, wastes energies on the part of the physician which could be employed to better advantage, but is evidence of a degree of loose thinking which is sorely in need of correction. From this point of view also, therefore, it is important to have more knowledge of the ways of working of the mind, not only as it may get out of order but as it may operate in the physician to distort the facts of observation and even his own motives. For all of these reasons mind needs to be studied in medicine, not in a superficial way of describing a few types of disorders by recounting their prominent symptoms in a course in psychiatry, but seriously, as a fundamental importance to adequate understanding of human individuals and as a phenomenon which, to be understood, needs to be studied from the standpoint of the broadest biological approach.

Disease is to be considered only as a manifestation of that dynamic interplay between organism and environment when the organism, for some reason, is losing out. In other words, it is a process of dedifferentiation on a large scale. It can be readily understood how this is true, say of the changes incident to old age, but it is equally true of less obvious situations such as the infections. Infection does not equally afflict everyone. Some are relatively immune, others relatively susceptible. There is an underlying orientation of the organism towards the infectious agent, vaguely referred to

as constitutional, which but exemplifies the fact that the result is the outcome of the dynamic interplay between organisms and environment. Then when the study of pathology is approached it is found that there is nothing new. This order is found among the normal physiological processes but nothing new has been added to the situation. The only differences are quantitative, differences more or less in degree, and not in kind. Pathology is only a study of physiology modified by differences of emphasis here and there. Disease is, therefore, as I have previously stated, not an extraneous something like a medieval devil, but a function of the dynamic interplay of the organism and environment, and the study of disease alone, as disease, can never give complete account of the reasons for the symptoms.

As an illustration of mind over body I desire to enumerate a few examples. Emotional disturbances can be etiological factors in diabetes, jaundice, urticaria, paralyses, cancer, gastric diseases, retention of urine, amenorrhoea and anasarca. The intellect, on the other hand, has a much less intimate connection with organic procedure. The emotion in its varieties is often wholly or partially unconscious, whereas the intellect is almost always exercised consciously, though its effects upon the body are wrought by the unconscious mind apart from the direct action of the will. The results are therefore much shallower and more superficial, and nearly always functional.

The mind can also influence and produce indirectly through the unconscious mind hyperaesthesia, anaesthesia, paraesthesia, dysesthesia, and all varieties of special sensations. The mind can contract or relax muscles, and cause all movements, including irregular and excessive movements, spasms, and convulsions. The mind can also produce loss of muscular power and paralysis. It can in the same way influence the involuntary muscles of the heart, lungs, bloodvessels, bowels, also those in all organs; it can affect the salivary and mammary glands, digestion, excretion, secretion, and general nutrition.

The sympathetic system, which is largely governed by the mental emotions, causes functional diseases of all parts and many organic diseases such as inflammations, goitre, headache, angina pectoris, diabetes, Addison's disease, and neurosis of extremities. It is interesting to note, in comparing the voluntary and involuntary systems, that it is decidedly the former which to some extent is under the control of the conscious mind and which is most easily paralyzed and suffers most from the disease. Mental overstrain is a more frequent cause of morbid conditions of arteries, heart, and kidneys than is generally admitted. Hence arteriosclerosis is so common among physicians, attorneys and financiers. The emotion of anger has been especially investigated with reference to arterial pressure. It is found capable of increasing the blood pressure to a great extent.

Vomiting is not only excited by injuries to the brain, apart from disorders of the stomach, but by the mind alone. On one occasion I gave a patient colored water and told her it was a strong emetic given in solution. She became violently sick in consequence. In connection with action of the mind on the digestive tract I desire to produce briefly a report of a case.

A young woman was admitted to the Central State Hospital. The patient's abdomen became greatly distended and she developed fecal vomiting. The case was thought to be one of intussusception, and laparotomy was performed by the late Doctor O. G. Pfaff. The whole of the abdominal contents was carefully examined and all viscera were found to be healthy; nevertheless the frequent vomiting was genuine. Three ounces of castor oil was introduced into the rectum which was vomited with fecal matter in about twenty minutes. The cause of this marvelous reversed peristalsis was purely mental, and the patient was eventually relieved by wholly mental discipline and therapeutics, and was discharged from the institution as recovered. Although this confessedly is a case of functional disease, it nevertheless remains one of the most remarkable instances of the power of the unconscious mind over the body ever to come to my attention. The power that reversed peristaltic action without any mechanical or material cause is not therefore only mental, but shown to be unconscious by two facts. The woman had no idea it was affected by her mind at all, and if she had, all her conscious power could not have produced it. What caused it, therefore, was neither conscious nor sub-conscious, but unconscious mind; and the disease necessarily remained incurable until this unconscious mind was reached, and made to undo the evil work it had done.

Apoplexy may occur during mental anxiety, being caused by arterial tension; also many cases of atheroma occur where no cause is known but some mental disorder. Also cardiac dilatation in young people which may be due to palpitation from increased vascular tension of mental origin have been observed. Turning to the lungs and breathing, asthma and various forms of dyspnoea, coughs and hiccoughs are largely influenced by the mind. I have known several cases of asthmatic patients in whom attacks were brought on by fear and seeing them in others. As to infectious diseases, the mind is a potent factor. A doctor owes his immunity to this fact far more than to any care he takes, and so do nurses. The surest way to be attacked with an infectious disease is to be afraid of it. Fear and the thought of sickness are of themselves sufficient to cause the same, provided the organism be present.

The action of a complex mental mechanism as a whole is shown exceptionally well in a case reported by Prince. The patient was subject to hay fever in a very severe form when exposed to roses. On one occasion a bunch of roses was unexpectedly

produced from behind a screen. A severe attack followed with lachrymation, congestion of mucosa, dyspnea, etc., although the roses, unknown to the patient, were but paper. Here a pure psychic fact at one end of the scale produced a set of reactions which at the other gave rise to sensory, motor, vasomotor, and secretory disturbances.

Dr. George F. Palmer, in an address presented in Indianapolis before the Indiana State Tuberculosis Association, stated: "It is generally conceded that from 80 to 90 per cent of the influences which determine the prognosis in tuberculosis are psychological and have to do with the emotional, mental and nervous reaction of the patient, but a large part of this restlessness is certainly due purely to emotional causes; to fear, uncertainty, disappointment and worry; all phases of that most demoralizing of human emotions, fear. This emotional disturbance may account for many of the distressing physical symptoms of the disease."

Just as these disease problems can be advantageously approached from this angle so can other similar problems be perhaps illuminated in the same way, for example, the problem why certain etiological factors, for instance, the tubercle bacillus should attack the lungs in one person, the kidney in another, etc. This opens up for consideration the whole great question of individual types of susceptibility to disease, a question which it would seem cannot be solved without at least taking into consideration the organism as a whole. The study, for example, of the relation of certain types of pulmonary tuberculosis to the shut-in type of character and the dynamic factor back of this character trait which may well be of more importance than the tubercle bacillus itself because, primarily, it offers a point of attack in prophylaxis, and because, unless dealt with, it makes a cure impossible. It has been in the past usual to explain such problems by heredity but this stamps the issue as final and irremedial and sterilizes effectually all thereapeutic efforts.

From this larger view-point it is apparent that the personality as an energy system can no longer be neglected in the study of the individual, either by the psychiatrist or the internist. Certain of the endocrinopathies, particularly thyroid and adrenal, at once suggest this angle of approach as offering problems which have as yet not been sufficiently organized to be laid down in structure. More clearly defined disease types such as diabetes suggest further study along these lines, while such organic conditions as chronic nephritis, pulmonary tuberculosis, and even cancer may have their etiology illuminated by a closer study of the life histories of those in whom they develop with a view to discovering the dynamic factors which have been at work through the life of the individual, and, operating as long continued stresses, finally have broken down the organic compensation in certain directions. Many chronic diseases may well be total life reactions which can only be fully understood when the psychological as well as the somatic symptomatology is taken into account.

Psychiatry, by its unremitting emphasis on the study of the personality make-up, first, to explain disease and later as necessary to understand the symptoms of disease when it does develop, has, by finally pressing physiology into its service, affected a union which for the first time really begins to recognize the importance of considering the individual as a whole. Internal medicine has thought that it was considering the individual as a whole, as a biological unit, when it considered all the organs and perhaps the most obvious of the personality traits. The study of the personality from the two opposite angles, the psychological and the physiological, has demonstrated the inadequacy of this assumption and indicated quite clearly that between these two lines of approach much more is comprised than heretofore suspected. Psychiatry is the first medical specialty which at all adequately approaches the problem of the whole individual.

Every physician knows how much more easily certain patients die than others. Every physician is familiar with the patient that gives up, ceases to make the fight, and the patient who, on the other hand, really apparently has no right to live at all but who by sheer force of will power gets through a serious illness. And there are many facts in the physical make-up of individuals that would make it appear that we have different types of persons so far as their reactions to disintegrating influences is concerned, and that the type of person that is able to compensate psychically is able to do so physically and vice versa. We know, for example, that certain individuals who die of diseases which have shown marked efforts at compensation along the way, such as cardiac disease, also when they develop psychoses they are compensatory in type, and that individuals who develop psychoses which are noncompensatory in type die of noncompensatory types of physical diseases such as intestinal intussusception; and that a given type of disease such as tuberculosis, when it effects the noncompensating type of individual, goes on rapidly to death, but when it affects a person of compensating type then we have the slow cases which are protracted throughout with fibrous processes and linger on for many years. We are also aware of the fact that among savages who believe firmly in the traditions and superstitions of their race, when they have offended one of the fundamental taboos they sometimes die, occasionally by committing suicide, but on the other hand sometimes by merely pining away without any evidence of special disease processes.

The medicine of the past has developed preponderantly along physical lines and in the direction of specialization, so that highly trained men have been functioning only too often as technicians interested in diseases and organs rather than sick

individuals. Psychiatry in its recent developments has been the only medical specialty that because of its nature was called upon to deal with the whole individual in any real sense. Psychiatry was forced more nearly to acting upon this principle than any other specialty; and now it has come about as a result of psychiatric investigations, psychiatric thought and the psychiatric point of view, that the individual has come to be vastly more important than any of his diseases or his organs. In fact the concept that considers the organism as a whole, and the necessary correlate thereto, that there is a psychological factor in every illness, bids fair to cause a revolution in medical thinking that will be of great significance in future medicine.

SIMPLE GLAUCOMA

Observation on Symptoms, Diagnosis and Treatment

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Glaucoma is a disease of the eye characterized by an increase in the intraocular tension. It is generally thought that glaucoma is not a purely local disease, but rather a local manifestation of disease conditions elsewhere in the body.

Although congestive glaucoma has been known since antiquity, it is only since the invention of the ophthalmoscope by Helmholtz in 1851, and the work of von Graefe and Heinrich Muller who was the first to demonstrate anatomically the excavation of the optic nerve (1856), that simple glaucoma has been recognized *per se*.

Intraocular tension is maintained by a balance between the secretory and excretory mechanisms in the eyeball, and the normal tension exerts a force equivalent to a column of mercury twenty to twenty-five millimeters in height. Any imbalance in either of the afore-mentioned mechanisms causes an increase in intraocular tension. Thus, an increase in tension may be caused by an overproduction of aqueous with a normal avenue of escape, or production may be normal and the drainage diminished. According to present knowledge, the evidence of this disturbance in relationship between the secretory and the excretory mechanisms is in favor of a failure of the drainage mechanism.

It is not the intention of the writer to go into any great detail regarding the various theories of the cause of glaucoma, but brief mention of the more recently advanced theories may be of interest.

It has been found that in patients with a shallow anterior chamber the size of the pupil affects the intraocular tension. After a stay in a dark room the tension rose markedly, returning to normal within a short time after the patient returned to the light. This difference in tension is explained by an obstruction in the chamber angle when the pupil is dilated. Some observers believe that the iris and ciliary body are the principal sources of aqueous, while others contend that the aqueous is a dialysate of the blood, and its formation dependent upon vascular changes; hence, vascular disturbances are of great importance in its formation and in the production of glaucoma. In regard to the relation between increased intraocular tension and increased blood pressure and arteriosclerosis, some investigators[1] stated the belief that "high blood pressure itself can not affect the intraocular tension unless accompanied by sudden change of pressure or disturbances of vasomotor control which allow acute capillary dilatation." The relation between glaucoma and endocrine imbalance, as evidenced by the frequency of glaucoma at the time of the menopause, is as yet too obscure to allow any definite conclusions.

It has also been found that low grade inflammations are factors in many cases, by producing venous stasis or increasing capillary permeability, or both.

The onset of simple glaucoma is extremely insidious. At first there may be no symptoms of any kind, no evidence of tension, no pain. No symptoms are produced until the intraocular tension has risen to the point which indicates changes in the structures of the eyeball. As the disease progresses the patient will notice that his vision is not quite as clear as it should be; he may also observe that he is unable to see distinctly at the close point. These symptoms of failing vision and premature presbyopia are among the first that are noticed by the patient, and always are looked upon with suspicion. The vision can be corrected with proper lenses, but they usually are satisfactory only for short periods when it again becomes necessary to have the eyes refracted. As the disease progresses the patient may notice concentric contractions of the field of vision which occurs particularly on the nasal side. This contraction gradually encroaches upon the fixation point until the patient is unable to see anything except what is directly ahead of him, which is called "gun-barrel" vision. If the gradual increase in intraocular tension is not checked, it will ultimately result in total blindness. The patient may or may not notice colored halos around artificial lights. This symptom, which the textbooks state is characteristic of glaucoma, is not as common as one would be led to suppose, and in the writer's experience, it is the exception rather than the rule.

Although glaucoma is a disease which occurs usually in middle life or later, there are a number of cases on record in which it has occurred in younger individuals. Because of the very gradual increase in the tension, there may be no external evidence of the disease, so that glaucoma in its

[1] Gifford, S. R.: *Pathogenesis of Glaucoma. Arch. Oph.* 3:88-98, 1930 (January).

early stages is sometimes over-looked. The eye may seem quite normal in appearance, or slight dilatation of the pupil may be observed, and sluggishness in its reaction may be present. Any individual past middle age, with a pupil larger than three millimeters in diameter, should be looked upon as a potential glaucoma patient. This moderate dilatation of the pupil is one of the important manifestations of early glaucoma. Slight increases in the intraocular tension are not readily detected by palpation with the finger-tips. The only accurate method of determining the tension is by means of the tonometer, of which there are several varieties, the one devised by Schiötz, or one of its modifications, being the most widely used.

Intraocular tension varies from day to day and in the same individual it varies at different times of the day. In general, it may be said that a tension which remains persistently above twenty-five millimeters of mercury is indicative of glaucoma. The chief diagnostic point is the picture presented by the ophthalmoscopic examination. The change seen in the optic nerve consists in a depression or a total excavation of the optic disc due to the increased pressure, the depth of the depression corresponding to the duration of the process. The optic disc generally appears whiter than normal, due to the atrophy of the nerve fibers, and this again depends upon the duration of the disease. Changes in the field of vision and enlargement of the blind spot are determined at first only with special forms of perimeters, and great care is required in making the test. At first there will be noticed a slight contraction, particularly on the nasal side. Unless the disease is checked, this contraction gradually encroaches upon the fixation point until all sight is destroyed. Inasmuch as the central vision may remain good until the very last, it is necessary not only to test the visual acuity but also to study carefully the fields of vision. It cannot be too strongly emphasized that the moderate increase in intraocular tension and the slight early changes in the visual field precede the characteristic changes or rather the appearance of the optic disc, as seen with the ophthalmoscope. Because of the very slowly developing symptoms, the patient himself often does not become aware of the existence of his disease until late.

There is not much chance of mistaking simple glaucoma for some other disease, because of the absence of external symptoms. The great danger lies in the failure to recognize the disease in its early stages, before it has progressed to the point where the continued hypertension has produced failing vision, contraction in the visual fields, and cupping of the disc. The possibility of the presence of glaucoma in patients in middle life or later should be constantly borne in mind, so that the disease can be checked in its incipiency, before irreparable damage has been done.

Treatment

The treatment of simple glaucoma is non-surgical and surgical. It is the opinion of many ophthalmologists that sooner or later all cases of glaucoma will require surgical intervention. S. R. Gifford[2] states that it has been his experience to see many more bad results from postponing surgical intervention than from unsuccessful operations.

Many ophthalmologists believe that the patient's general condition is of great importance in the successful treatment of glaucoma, and that obvious foci of infection such as diseased tonsils, infected teeth, intoxications of the gastro-intestinal tract, etc., should be eradicated. Other observers do not attach the same importance to general constitutional corrective measures. Gifford states, "... I have seen only two general conditions which seem to have undoubted etiological relationship to glaucoma. These are the so-called vaso-neurotic diathesis, and the related condition of bronchial asthma. The vaso-neurotic diathesis includes persons of unstable vaso-motor mechanism and usually unstable nervous mechanism, as shown by tachycardia, flushing, angio-neurotic edema, and urticaria." It is a well known fact that emotional disturbances such as extreme anxiety, worry, excitement, anger, etc., often precipitate attacks of glaucoma.

A number of drugs have been used in an effort to reduce tension with more or less success, but only those which have proven to be of particular value will be discussed.

In the non-surgical treatment, the miotics, pilocarpine and eserine, should be tried before anything else is done. The use of these drugs will generally produce a reduction in tension for a varying length of time. It is well to start with pilocarpine as this is much less irritating than eserine. The weakest solution that will keep the tension down within normal limits should be used. The reason for this is that patients establish a tolerance for the drug, and it is necessary gradually to increase the strength of the solution in order to keep the tension low. The same is true of the more powerful miotic, eserine. If, after careful observations with the tonometer, the tension is not reduced appreciably with pilocarpine, eserine should be tried, beginning with a weak solution. Eserine is more irritating to the eye and hence its continued use may cause a conjunctivitis, in which case it can be alternated with pilocarpine. Even with the use of miotics, the tension should be taken at frequent intervals, as should also the vision and particularly the visual fields, for in some cases, in spite of an apparently normal tension, the fields gradually contract, indicating that at some times the tension is too great for the tissues to withstand, and it becomes necessary to adopt other means of reducing the tension. As stated before, the tension

[2] Gifford, S. R.: Some Non-Surgical Aids in the Treatment of Glaucoma. *Brit. Jrnl. Oph.* 1929 (October).

varies not only from day to day in the same individual, but at different times during the same day, so it is the custom with some ophthalmologists to record the tension in the eye at three-hour intervals for several days in order to determine the maximum elevation. In another group of cases miotics exert a beneficial effect for a short time only, and if, in spite of their continued use, the tension remains above normal, it is necessary to consider operative interference.

Among the more recent methods of reducing tension is the use of adrenalin or glaukosan—the latter name being given to dextro-rotatory adrenalin, which has the property of reducing intraocular tension without producing a rise in the general blood pressure. Ordinarily, adrenalin instilled into the eye produces a dilatation of the pupil with a marked reduction in tension, and is particularly efficacious in simple glaucoma in reducing the tension before operation or when combined with miotics to allow postponement of operation for long periods.

The intravenous use of hypertonic salt solutions while particularly beneficial in reducing tension in acute glaucoma, on the theory that they cause absorption of fluids from all the tissues, including the eye, may be used in any form of glaucoma and is without danger.

Use of ergotamine, which by its depressant action on the sympathetic nerve terminals, thus causing a decrease in the permeability of the blood vessels, on the theory that hypertension is produced by hyperactivity of the sympathetic system, has proved to be of value in reducing the intraocular tension.

In regard to the surgical treatment of simple glaucoma, the question arises as to when to operate, and also what type of operation to perform. In general, it may be stated that when the tension can no longer be controlled by the use of miotics, or other drugs, and in the presence of failing vision and contracting visual fields, surgical intervention is absolutely necessary. Ordinarily, the sooner operation is performed, the better the chances are for preventing injury to the tissues of the eyeball. The choice of operation depends largely upon the operator and the circumstances under which it is to be performed. Many favor the Elliott's trephine, or one of its modifications, such as the LeGrand sclerectomy, as being the best for a filtering cicatrix. Other operators prefer one of the iris inclusion operations such as iridotasis or iridencleisis. The prognosis of any operative procedure depends entirely upon the amount of damage which has already been done by the increase in intraocular pressure. Thus, in those cases in which visual acuity is reduced by changes in the optic nerve, operation cannot correct these changes. The best that can be hoped for is to prevent the condition from getting worse by checking the progress of the disease.

Case Reports

In the following cases, reported in brief, a careful study was made of the vision, the changes in tension as shown by the Gradle-Schiötz tonometer, the visual field, the ophthalmoscopic picture, etc.

Case 1. Mrs. J. C. B., aged forty-five, was seen February 20, 1928. Diagnosis was made of simple chronic glaucoma of both eyes. She gave a history of gradual diminution in vision, extending over the past three or four years. The vision in the right eye was $15/10 - 2$, and in the left eye $15/15 + 2$. The tension was, right eye, thirty-four; left eye, forty. Ophthalmoscopic examination revealed a marked cupping of the disc, more pronounced in the left, and seemed to involve particularly the temporal side of the disc. The visual fields of both eyes were contracted and there was a large paracentral scotoma in the left eye. The patient was put on treatment with miotics, which seemed to be of little avail in keeping the tension within normal limits. On July 5, 1928, an iridotasis was performed on the left, with good results. One month after the operation the scotoma in the left eye had diminished considerably in size, and there has been no further diminution in the field of vision. The patient has been under observation since the operation and the vision has remained normal with the tension fluctuating between thirteen and twenty. So far, the use of miotics in the right eye has kept the tension down with no decrease in either the vision or the visual field.

Case 2. Miss A. K., aged forty-five; seen October 14, 1919, with a history of attacks of blurred vision which lasted for forty-eight hours or less, beginning about a year previously. Recently she has had some pain in the eyes and noticed halos around artificial lights. At the time of her examination, the vision was 15/15 in each eye with correcting lenses. External examination revealed a slight shallowness of the anterior chamber and the pupils were normal in size and reacted actively to light and accommodation. Ophthalmoscopic examination revealed no cupping of the optic discs. The tension in the right eye was twenty-four—in the left eye, fifteen. The patient was put under treatment with miotics, with the result that the blurring of vision and the halos around artificial lights disappeared. She has been under observation since that time, and the tension has been kept down fairly well with the use of miotics. The vision has remained normal and there is only a slight contraction of the visual field and no central scotomata. Recently the tension has been elevated, ranging between thirty-one and forty-five, and if this condition persists it will be necessary to resort to operative interference.

Case 3. Mr. O. S. P., aged sixty-four; was seen May 23, 1931, with a simple chronic glaucoma of each eye. Vision in the right eye was 15/15; in the left eye, $15/50 - 4$ (due partly to an incipient

cataract and floating vitreous opacities). The tension was sixty-eight in the right eye, and seventy-one in the left. On May 25, 1931, a trephine operation was performed on the left eye, with resulting reduction in tension to twenty-four. Treatment with miotics caused no appreciable reduction in tension in the right eye, and on July 3, 1931, an iridotasis was performed, with resulting reduction of tension to seventeen. The tension in the left eye kept gradually increasing, in spite of the trephine operation, so that it was thought advisable to do an iridotasis which was performed on July 11, 1931, and which caused a reduction in tension to twenty-four. Since this time there has been no further reduction in vision of the left eye and the tension has remained normal. The vision in the right eye has been normal with correcting lenses until recently, when the vision began to decrease because of the development of an incipient cataract.

SOME CONSIDERATION OF THE PROBABLE EXCITING FACTOR IN PERFORATED PEPTIC ULCER*

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Within the past twelve years over four thousand cases of perforated peptic ulcer have been recorded in the literature. There has been ample discussion of the various problems associated with this calamity. The pathology has been accurately described. Symptoms and signs are well known to every physician and surgeon. The treatment is now applied on the basis of ample clinical and experimental observation, and the prognosis is dependent almost entirely on the time factor. There is, however, a phase of this subject little understood, and therefore subject to much controversy. This particular aspect of the subject has not been sufficiently discussed or studied. I refer to the exciting cause or causes immediately active in the perforation of a peptic ulcer.

Nor is such a discussion entirely academic. Honestly interpreted, it leads to a knowledge which is important in the guidance of patients with ulcer, as it informs us of the probability of the calamity of perforation to occur, and it instructs us in informing the courts correctly in medico-legal cases.

THEORETICAL CONSIDERATIONS

Corlette[3] studied the problem from the standpoint of the physicist. He is of the opinion that since the abdominal cavity is a closed one, partly rigid and partly elastic, and since its contents are mostly composed of intestines containing air and water, that any force in the abdomen acts as a hydrostatic force and he concludes, "It is shown by Boyle's law that no increase of general intra-abdominal pressure can cause a strain of an ulcer and a perforation cannot occur from that cause . . . But contraction of the muscle walls of the stomach can produce it, because this would cause the pressure in the stomach to be greater than the pressure in the abdominal cavity."

At first glance this seems to be an accurate deduction on purely physical laws. However, when thinking in such terms we must consider all of the laws of physics that are applicable; and we must remember that we are dealing with the human, who is not always governed by purely physical laws. Among other factors we must recall that the strain upon the stomach wall which results from increased intra abdominal pressure will not be equally distributed, for the stomach wall is not isotropic, particularly in the presence of an ulcer, nor is it movable to a position where all forces applied may be equal. We know that, due to adhesions and even the normal ligamentous attachments of the stomach its movability may be limited. It must be obvious that if the stomach lies anteriorly at the time that trauma is applied it would receive a disproportionate amount of the force and a weak spot such as exists in ulcer would give way and perforate. Then too, the consistency of the stomach content because of its density would tend to be forced outward. Lastly, the assumption that the abdomen is an "elastic bag" may be erroneous. We shall show presently that the roof, walls and even floor of the upper abdominal cavity can make direct pressure upon the stomach without the intervention of a hypothetical hydrostatic pressure bag.

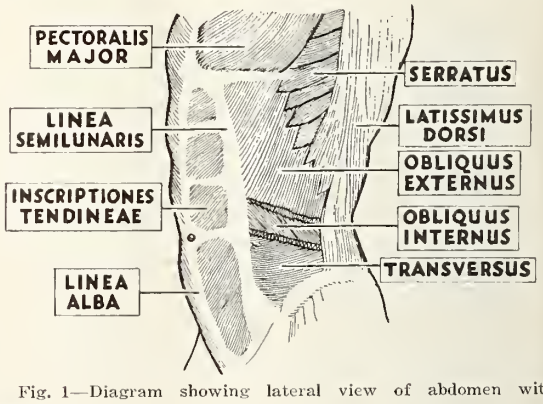


Fig. 1—Diagram showing lateral view of abdomen with muscles.

Some ulcers perforate clean with the peritoneal coat even and regular while the mucosa is ragged, while others show the peritoneal coat to be ragged. This is accounted for by the fact that the peritoneum quickly attempts to seal the defect. In small perforations within one-half to three-fourths of an hour the peritoneum has begun its reparative work —a "pulling in" evidently occurs making the perforation appear clean. Whereas in large perforations the edges are so ragged that in spite of this quick healing action of the peritoneum the wound still has an uneven appearance.

* From the Department of Surgery, Indiana University School of Medicine, Indianapolis, Indiana, November, 1932.

Burt[3] showed the mechanism of perforation of intestines and the pressures required, by experimenting on dogs. He introduced air into the gastro-intestinal canal and observed the pathology of perforation. He concluded that the stomach has the least resistance to increased pressure and is perforated easily. His illustration shows the ragged edges mentioned above as found in large perforations.

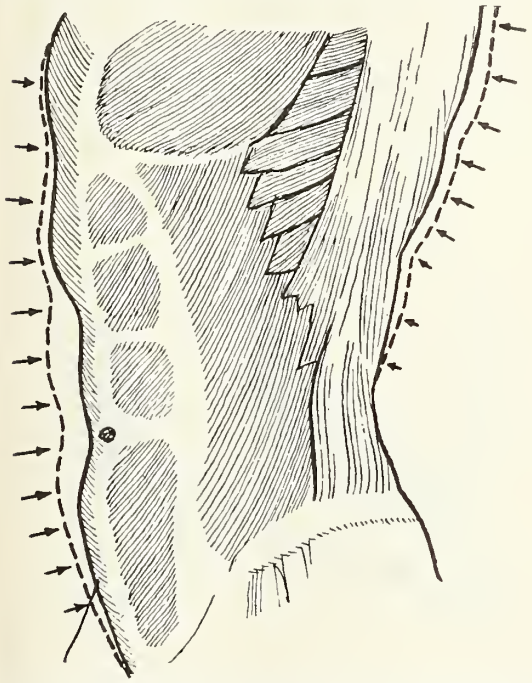


Fig. 2—Diagram showing contraction of the abdominal muscles when traumatized or strained. Note the decrease in anteroposterior diameter and the pull upward of the external oblique.

Overholt[3] studied intraperitoneal pressure in dogs by means of a cannula in the abdominal cavity. He noted that normally the intra abdominal pressure was lower during inspiration due to a relaxation of the abdominal walls which was more important than the lowering of the diaphragm. But if the animal strained, then the intra abdominal pressure was increased during inspiration (diaphragm descent) and decreased during expiration (diaphragm ascent).

We[4] have seen two cases of rupture of the intestine without external wound and reported them. They were in normal boys with sound gastro-intestinal tracts. The literature contains many such cases. In our cases as well as those reported there is a ragged wound on the anti mesenteric border—clearly the result of an explosive force due to increased intra abdominal pressure transferred as an increased intra intestinal pressure. If a normal intestine will do this then surely a stomach or duodenum with an ulcer will give way much more easily. At this point we should recall that the destroyed muscular coats of the stomach or duodenum in ulcer do not become repaired by new muscle fibres. Fibrous tissue fills in the gap. During healing the new mucous membrane grows over delicate granulation or squeezes the granulation tissue out into the lumen of the stomach much like a mushroom. The thin loosely attached mucosa may strip from the friable granulation base and a perforation easily occur even during the healing stage. This will be referred to later in connection with the frequent perforations in symptomless ulcers. It also explains the relative infrequency of perforation in those cases with the most active symptoms—for here a protective peritoneal reaction has occurred.

The uncommon accident of a perforation of the stomach during fluroscopic examination bears evidence to the fact that even the slight increase in intra abdominal pressure due to this very gentle manual manipulation is not without danger, a fact keenly appreciated by most roentgenologists. This may occur even when a small amount of barium is used. It is therefore not the overloading of the stomach with barium that is at fault.

It has occurred to us that the frequency with which ulcer perforates in men at work is evidence of the fact that there must be some relationship between the perforation of an ulcer and muscular effort or trauma. We shall attempt to prove this by:

1. A study of the literature on the subject.
2. A study of the behavior of the human stomach in the living as observed under the fluoroscope.
3. A study of our own cases and case records in our hospitals, together with a statistical evaluation of the above studies.
4. Logical deductions from all available facts.

Literature on the Subject

Zuckschwerdt and Eck[5] studied 117 cases. They found that 63 per cent of the perforations occurred in laborers while doing heavy work. They conclude as follows: "Apparently variations of pressure in the abdomen resulting from heavy work may favor perforation. This is suggested by the fact that in two-thirds of the cases perforations occurred during the day."

Judine[6] studied 116 cases. His conclusions are as follows: Only 1.4 per cent were women, al-

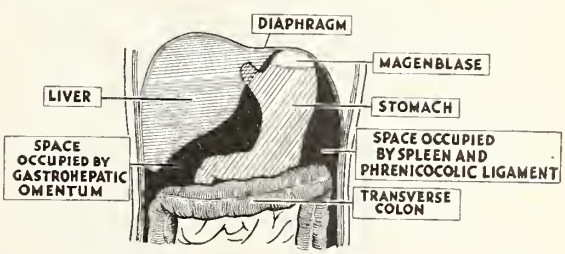


Fig. 3—Diagram illustrating the "Upper Abdominal Compartment." The roof is formed by the diaphragm and left lobe of the liver; the floor by the transverse mesocolon; and the anterior, posterior, and lateral walls by the abdominal muscles.

though the general frequency of ulcer in women is 13 per cent. The relatively low incidence of perforation in the female can be explained only by less intense physical activity and more regular habits of daily life. Eighty per cent were between twenty-six and forty years of age. Occupation obviously had a part in the etiology as fifty-six of the patients were laborers and seventeen were motormen, conductors and postmen. The perforation usually occurred between 3 and 6 P. M. A negative history is common.

Magnant[7] found records of nine cases of perforation of an ulcer after a contusion of the abdominal wall. To determine what happens to the stomach when a sudden blow is sustained in the epigastric region, Magnant made studies with the fluoroscopic screen. Following his suggestion we made observations upon the human stomach under the fluoroscope. I am deeply indebted to Drs. Wright and Lochry for the aid given me in these studies.

Results of Fluoroscopic Studies

Let us look at the upper abdominal compartment through the fluoroscope. With the patient in the standing position, we note that the diaphragm forms a dark biconvex line. With each inspiration it descends, with each expiration is ascends. Immediately beneath the left dome of the diaphragm, in the fundus of the stomach may be seen the gastric air bubble (Magenblase). If we percuss the abdominal wall we observe that the diaphragm is momentarily arrested and then descends in the position of forced inspiration. This happens whether the diaphragm is up or down at the moment the blow is received. At the same time the anterior abdominal wall is forcibly contracted. This is nature's way of resisting the external force. The stomach is thereby pushed back and is compressed in a semi-rigid frame formed by the left lobe of the liver and the left dome of the diaphragm above, the transverse mesocolon below, and the abdominal wall in front and back. As a result of this stress the fluids and air in the stomach are forced against the stomach wall. Intragastric pressure is greatly increased and if an ulcer is present a point of weakness is created which may give way and perforate. The changes as above described are seen in a more prolonged fashion when the patient leans forward and strains while lifting a heavy object. The gastric air bubble becomes slightly flattened, while the transverse diameter of the stomach is increased.

A counterpart of the above situation was devised by Reed[8] in an effort to solve the problem of perforation. He placed one rubber bag within another and exerted pressure on the outer one. If the outer bag touched the inner one, the latter ruptured. In the human the outer bag is the "upper abdominal compartment" exerting direct pressure on the inner bag which is the stomach. Magendie[9] further proved the power of the upper abdomen to bring direct pressure on the stomach wall. He extirpated the stomach of an animal, substituted a bladder containing water and connected it with the oesophagus. Injection of an emetic caused a typical vomiting movement with ejection of the contents of the bladder.

The evidence gleaned from the literature and fluoroscopic observation seems to point to the fact that trauma either due to blunt force applied to the abdomen, or increased intra abdominal pressure due to muscle strain, is certainly a causative factor in a great many instances. Physiologists help explain this relationship by demonstrating that during work gastric secretion may be increased and strong peristaltic waves may occur.

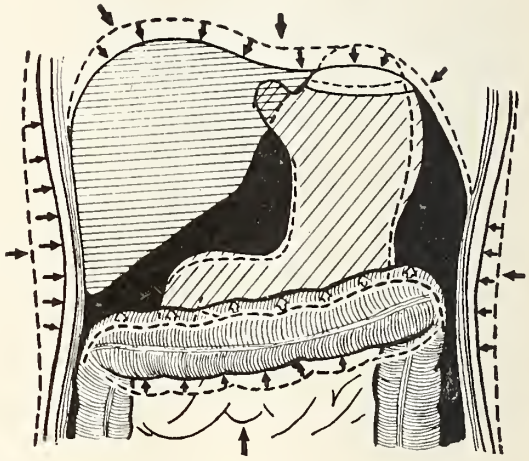


Fig. 4—Diagram illustrating how the stomach is compressed in the "Upper Abdominal Compartment" as a result of trauma or muscle strain. Note the descent of the diaphragm, the ascent of the transverse mesocolon and the decrease in the lateral diameter of the upper abdomen.[1] The result is a direct pressure on the stomach as evidenced by a flattening of the magenblase and an increase in the transverse diameter of the stomach, accompanied by a decrease in its longitudinal diameter.

Statistical Studies

We are all aware that statistics may prove anything depending upon one's interpretation. However the figures here presented are composites of a large number of cases and are therefore fairly reliable. These are compared with our own studies for which I am indebted to Drs. Lord, Creel, Kohlstadt and Rogers.

Perforated peptic ulcer occurs in about 7 per cent of all ulcer cases (Finney[10]). There is one female to twenty-one males whereas ulcer in general occurs in one female to three males. This bears out the previous claim that heavy work is of etiological importance. The age group in which perforations are most likely to occur is between twenty-six and forty. This is the period in life of heaviest physical strain. The occupation as revealed by our study of the literature was that of laborer in 63 per cent. Our own survey based on a study of 180 cases shows that the occupation was

definitely recorded in eighty-nine cases. Of this number fifty-two, or 58.4 per cent, were laborers under various classifications. Draper, Pende and others have shown that peptic ulcer occurs more frequently in a peculiar linear type patient whose occupation is more often clerical. We therefore find that whereas the general incidence of peptic ulcer is less frequent among laborers—yet the incidence of perforation is greater among them. This would indicate an occupational association.

We wanted to know if a patient with a perforated ulcer had symptoms previously. We found that in 46 per cent of our cases he had experienced gastric symptoms for a time, but in 54 per cent he did not have. This is in line with the experience of other investigators. The majority of perforating ulcers are symptomless. However, we found that in over 60 per cent of our cases there was a definite warning twenty-four hours prior to perforation.

It has been held by some that ulcers under treatment do not perforate. Hinton[11] presents six cases that did perforate while under medical management. However, we may say from our own survey that only 38 per cent of our cases had received any medical advice at all. We believe that the chances for perforation are greatly minimized by treatment of even the most perfunctory kind.

Da Costa[12] states that "perforation is usually brought about by muscular effort, and is most common after a full meal, but it may occur when the patient is quiet and has not eaten for some time." In order statistically to prove this statement we studied the activity as recorded in seventy-eight of our patients at the time of perforation, as follows:

At rest or in bed	21
Following heavy meal	9
following alcoholic debauch	2
Doing heavy work	46

In other words, the perforation occurred during strong muscular effort in 69.5 per cent of our cases. This is certainly more than a mere coincidence.

We are aware that gastric and duodenal ulcer are different species of disease in a great many ways. However, they are both peptic ulcers and have therefore been classified together in this presentation. In our series of cases eighty-six were recorded as gastric ulcers and seventy-seven were recorded as duodenal, seventeen had no record of the site of the ulcer. This is at variance with published statistics for Boger[13] in a study of 1,767 cases found that 66 per cent were perforated duodenal ulcers. Perhaps this may be explained by the prevalence of duodenal ulcer in his particular locality rather than the greater liability to perforation in the duodenum. Or more likely—some men are calling all ulcers close to the pyloric ring gastric. We may say in general without going into a technical discussion that from published statistics and anatomical considerations perforated duodenal ulcer is more common than perforated gastric ulcer.

Conclusion

We may therefore logically deduce from our studies that:

1. Excessive strain of the abdominal muscles from any cause may so fix the ulcerated stomach or duodenum as to increase intragastric pressure and thereby cause a perforation to occur.
2. Trauma to the abdomen may cause an ulcer to perforate by direct force, if the stomach lies anteriorly at the time that the injury occurs.
3. Treatment minimizes to a very great extent the incidence of this complication.

The author wishes to express his thanks to Dr. W. D. Gatch for many helpful suggestions.

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THE CONVULSIVE DISORDERS OF INFANCY AND CHILDHOOD*

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The subject of convulsions in infancy and childhood is one of extreme importance, not only to those who confine their practice to the diseases of infants and children, but equally so to the general practitioner, for it is the man in general practice who most frequently has to deal with this alarming occurence which constitutes the most common medical emergency of infancy.

Convulsions are involuntary, irregular discharges of motor impulses from the cells of the brain, resulting in muscular contractions.

There are several theories as to their causation. Soltmann[1] believed that "there is an imperfect development of the inhibitory control of the cerebral nerve cells in early life with an increased reflex irritability of the lower centers." Kussmaul and Tenner[1] believed that "anything which interfered with the blood supply of the brain might cause a convulsion," while Nothnagel,[1] showed that a mechanical irritation of the fourth ventricle or pons would produce convulsions.

A more recent theory, and one which is more convincing, came into prominence about the beginning of the century. It considers that infants suffer more frequently from convulsions than older children because there exists in them a state in which the calcium metabolism is more readily deranged.

Morse[2] has said that "one of the predisposing causes of convulsions is infancy and that they are not a disease entity but an expression of a variety of different conditions provoking cerebral discharges." He also believes that heredity plays a part in the etiology of convulsions in early life as the children of neurotic parents and belonging to neurotic families are more prone to have convulsions than those coming from more stable stock.

The causes of convulsions in infancy and childhood fall into five main groups: (1) Organic, (2) toxic, (3) metabolic or chemical, (4) idiopathic, and (5) reflex.

Convulsions occurring in the newborn are rarely toxic or metabolic but are more frequently organic in origin. There is an increased proportion of organic causes in the newborn which contrasts with the reverse condition in older children. This is due to the greater opportunity for injuries to the head with associated intracranial hemorrhage or edema, and to the prevalence of congenital defects manifesting themselves at this age. Intracranial hemorrhage, either traumatic or asphyxial in origin from a prolonged and difficult labor, is the most common cause. The convulsions are either tonic or clonic in type, usually begin within the first forty-eight hours after birth, and may or may not be accompanied by temperature. Between the attacks the infant is either extremely drowsy or irritable, refuses to nurse, has attacks of cyanosis, and usually has a bulging fontanelle although this sign may be absent if the hemorrhage is small, diffuse, or entirely subtentorial. In all cases of convulsions of the newborn, the first procedure necessary for diagnosis and treatment is a lumbar puncture. The importance of lumbar puncture cannot be overemphasized, for it has been shown in a large number of cases followed over a period of years that early diagnosis and lumbar puncture repeated as often as is necessary to maintain the spinal fluid pressure within normal limits makes it possible for these infants to survive and to grow to adult life without the usual sequelae of birth injury, in about 33⅓% of the cases. The spinal fluid usually shows gross blood. At the same time parental blood should be given in thirty to fifty c.c. amounts intramuscularly or intravenously, as it is impossible to be certain whether or not one is dealing with an associated hemorrhagic diathesis.

In infants, when the convulsions are accompanied by high temperature, bulging fontanelle and rigidity of the neck, meningitis should immediately be suspected. In older children the onset may be accompanied by a convulsion but the predominant symptom is usually headache which is accompanied by temperature elevation, irritability and persistent vomiting.

The toxic causes of convulsions may be due to substances introduced into the body from without or toxins elaborated within the body itself. In the former class we have the toxemia of pregnancy, for an infant born of an eclamptic mother may suffer from fatal convulsions. Some of the more common drugs which runabout children may accidentally ingest and which cause convulsions are atropine and strychnine. The encephalitis associated with lead poisoning is an occasional cause of convulsions. In the nursing infant the source is usually a lead nipple shield or an ointment containing lead which has been used on the breast of the mother and incompletely washed off before nursing. In the older infant and child the source is to be found in the paint which the child has nibbled from his crib, the furniture of the house or window sills. The immediate treatment of the convulsions is to reduce the intracranial pressure by intramuscular or intravenous magnesium sulphate and then to bring about the deposition in the bones of the lead which is in the circulation. This is best done by feeding large quantities of milk, to which calcium lactate has been added.

In the convulsions caused by those toxins which are generated within the body, the various acute infectious diseases play the most important part. They are very common at the onset of pneumonia, acute otitis media, scarlet fever, pyelitis, etc. Kerley[3], states that "over ninety per cent of the cases of convulsions coming under his notice have been due to gastro-intestinal disorders, most fre-

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quently in the form of acute indigestion, due to unsuitable articles of food. Rachitic children have also supplied many of these cases." It is likely that latent tetany is largely the responsible factor in Kerley's cases. In general, convulsions occurring at the onset of an acute infection have a more favorable prognosis than those which occur during the course or in the terminal phases of the disease. Convulsions occur more frequently in whooping cough than in any other infectious disease. It has been the training of most of us to consider these as being due to asphyxia, edema or hemorrhage of the brain and in a certain percentage of the cases one of these conditions obtain. Recently, however, Powers[4], has shown that many cases of whooping cough with convulsions have tetany as their basis, as indicated, if not by physical signs, then by lowered blood calcium or by electric hyperirritability of the nerves.

Frequently convulsions ending fatally are associated with enlargement of the thymus and the condition known as status lymphaticus. This occurrence has led some men to assume an etiologic relationship between the enlarged thymus and the convulsions, but the truth of this supposition is certainly open to a great deal of question. Morse[2], has said that he has never seen a single convulsion which he thought could be attributed to toxemia from the thymus or pressure due to its enlargement.

One of the most important toxic causes of convulsions in childhood is the so-called uremia or, better, the acute cerebral edema which complicates acute glomerular nephritis. You are all familiar with this type of nephritis which develops most frequently, during or following an acute upper respiratory infection, cervical adenitis or scarlet fever.

These children, frequently during the course of the disease, develop vomiting, headache, visual disturbances, coma or delirium and convulsions. Blackfan[3], has shown that these manifestations are due to an increased intracranial pressure caused by cerebral edema. With the increasing cerebral manifestations there is an increasing arterial hypertension and a visible edema, most evident by a puffiness about the eyes, and a rapid increase in weight. By decreasing the edema and blood pressure the coma and convulsions disappear immediately.

When one is dealing with acute hemorrhagic nephritis in a child the blood pressure should be observed very closely, as the best index to the condition of the patient and the amount of intracranial tension present. If the blood pressure is elevated, 50% magnesium sulphate solution in doses of one to three ounces every three or four hours should be given to bring about free catharsis, thus keeping the edema and blood pressure within reasonable limits by dehydration. If these large amounts cause nausea and vomiting it may be given by rectum. If this mode of administration does not suffice as evidenced by a gradually increasing blood pressure, when the patient begins having headache, vomiting and visual disturbances, 25% magnesium sulphate solution should be given in doses of .2-.4 c.c. per kilogram of body weight, deep into the muscle. If these measures fail to cause a fall of the blood pressure and a subsidence of the symptoms of approaching convulsions one can then give a 2% magnesium sulphate solution intravenously in the amount necessary to cause the blood pressure to fall to normal and the convulsions to cease. The amount is usually less than 150 c.c. and should be given at a rate not faster than 3-4 c.c. per minute.

The injection should be given by gravity into the vein of an arm while the blood pressure is followed on the other arm. Should signs of respiratory depression develop from the too rapid administration of the salt, the injection should then be stopped for a few minutes. If the depression becomes alarming, it can be relieved promptly by the intramuscular or intravenous injection of a 2-5% solution of calcium chloride. The intramuscular injection of magnesium sulphate solution may be repeated as often as every 3-4 hours with relative safety.

Graham[6], and his associates have shown rather conclusively that many of the convulsions of toxic origin in infants should really be placed in the metabolic or chemical group. They found that a large group of infants who had convulsions at the onset of acute infections, without the clinical or x-ray evidences of rickets or tetany, had lowered blood calcium values, and that the seasonal incidence of these convulsions followed very closely the seasonal incidence of tetany. They believe that the fever of the infection brings about a lowering of the blood calcium.

The most likely explanation of the cerebral pathology of the convulsions of toxic origin which one sees in older children is that of edema.

A case demonstrating this condition was recently seen at the St. Joseph Hospital. A boy of four years developed malaise in the morning, having been well previously, and in the afternoon suddenly had a convulsion which lasted several minutes. He was seen shortly after the attack by the family physician and sent to the hospital with a diagnosis of meningitis. Physical examination revealed opisthotonus, rigidity of the neck muscles, a positive Kernig and Brudzinski's neck sign and semi-coma, with a temperature of 105°. A lumbar puncture was done and the spinal fluid was found to be under tremendous pressure. As the spinal fluid was very slowly withdrawn the signs of meningitis completely disappeared. The following morning a roentgenogram of the chest revealed infiltration in the right upper lobe but the physical examination was entirely negative, the patient not even having dyspnoea or cough. Two days later the physical signs of pneumonia appeared. Convulsions of this type are usually rapidly controlled

by the use of magnesium sulphate by mouth, by rectum, or intramuscularly.

The majority of convulsions of infancy, occurring a few months after birth, are metabolic or chemical in origin. They are known clinically as tetany or spasmophilic convulsions. The usual age incidence is between six and eighteen months and most commonly between the ages of six and ten months. Several clinical conditions formerly described as distinct entities are now regarded as manifestations of tetany, e.g., convulsions, laryngismus stridulus, carpopedal spasm, and breath holding spells.

Hess[7] has summarized the pathogenesis of tetany in which he says "that a diminution of the calcium salts is the most important factor in the development of the condition. Tetany is usually associated with the healing of rickets, and in all probability is precipitated by the withdrawal of calcium from the body tissues due to increased calcification of the bone. However, the possibility of an absolute or relative excess of the phosphates, especially the sodium and potassium salts playing an important role, cannot be overlooked."

The gross chemical finding is a lowering of the blood calcium.

It has been known for a long time that the active symptoms of tetany occur most frequently between the months of January and May, reaching their highest incidence in March and April. Cameron[8] has shown experimentally that the symptoms of tetany may be induced by a fall of the barometric pressure, increase in air temperature and an increase in water vapor pressure. This results in a lowering of the oxygen content of the respired air. To meet this, the respirations increase, more carbon dioxide than normal is driven off, and a condition of relative alkalosis develops. The chemical balance is altered and active tetany results. If correct, this theory explains the tetany months since in the thaw of spring these sudden atmospheric changes are most likely to occur together. In addition to these conditions, the tetany months correspond with those months in which rickets becomes most manifest. Poor hygeine, lack of sunlight, secondary infections in the infant, and in all probability, the diet of the mother or that of the cows are all contributing factors.

Tetany is comparatively rare in breast fed babies and in infants who have received adequate amounts of standardized codliver oil. The early symptoms, such as child crowing, breath holding spells, and carpopedal spasm are frequently overlooked. The peculiar inspiratory crow, due to laryngospasm, often leads to the erroneous diagnosis of whooping cough or some type of laryngitis. The convulsions of tetany are not distinctive from convulsions due to other causes. There may be a single convulsion or there may be as many as twenty or thirty a day. If they occur in the months of January to May, are associated with a level anterior fontanelle and signs of rickets, one should look for the confirmatory signs of tetany, which are Chvostek's sign, peroneal reflex, Trousseau's sign, lowered blood calcium and Erb's sign for electric hyperirritability of the peripheral nerves.

Chvostek's sign is elicited by tapping over the branches of the facial nerve with a percussion hammer. It is positive when the muscles of that side of the face respond with a twitch.

The peroneal reflex is the same type of sign, which is brought out by tapping over the peroneal nerve as it passes around the head of the fibula, and is positive when the corresponding muscle group twitches.

Trousseau's sign is elicited by constricting the arm with a tourniquet for two or three minutes and is positive when carpal spasm is produced in the hand of the same side. This sign is pathognomonic when present but is frequently absent even in marked cases.

The normal blood calcium level in infancy is ten to eleven mgm. per 100 c.c. of blood serum. In tetany it is usually below 7 mgm., and is occasionally as low as four or five mgm. per 100 c.c. of blood serum.

Erb's phenomenon is a demonstration of quantitative changes in the reaction of the peripheral nerves to galvanic current. It is of value only when the determinations are made by an experienced person and is necessary only in doubtful cases.

The symptomatic treatment of convulsions will be outlined later and these measures should be used to control, immediately, the convulsions of tetany. As the convulsions are due to a lowered blood calcium, fifteen grains of calcium chloride should be given four or five times a day for four or five days and then continued over a three weeks period in ten grain doses, three times a day. The simplest method of giving the calcium chloride is to dissolve it in water and place it in the feeding. Standardized codliver oil, or one which has been fortified with viosterol, should be given in at least dram doses three times a day and, if possible, the infant should be exposed each day or every other day to the direct rays of the sun or a quartz mercury vapor lamp for gradually lengthening periods.

Josephs[9] in 1926, and Griffith[10] in 1929, reported a series of cases in which it was noted that after short fasting periods of about twelve hours these children would have convulsions which were associated with fever, vomiting and hypoglycemia. The convulsions cleared following the administration of glucose solution intravenously. They suggested that short periods of fasting may be a cause of convulsions in children, especially that type of convulsion which is seen at the onset of acute infection, and that these convulsions are hypoglycaemic in origin. They were, however, unable to prove their impression.

Idiopathic convulsions occur only in true epilepsy and one must differentiate, clearly, between this

condition and the epileptiform convulsions due to gross intracranial disease.

Boyer[11] states that one must have a definite idea of what constitutes the epileptic convulsion or one will be in danger of confusing all convulsions with this condition. His definition is as follows: "A seizure, to be epileptiform, must be transient, must impair or cause loss of consciousness and must ultimately result in some change, however slight, in the personality or in the mentality of the patient." This definition is applicable, not only to attacks of *grand mal* but also to the seizures of *petit mal*, where there are such symptoms as a sudden look of blankness, a momentary loss of consciousness, the dropping of some utensil, a fleeting stop in the performance of some action, in speech or in attention.

The history of such cases should be searched very carefully for a record of previous epilepsy in the family and for evidence of a familial neuropathy, for the influence of heredity is very decided, there being a history of antecedent nervous disease in nearly fifty per cent of the cases. The age is an important point in the diagnosis and prognosis, for epilepsy is with few exceptions not a disease of infancy. Boyer[11] studied 142 cases in children and found thirty-seven cases under two years of age; thirty-three cases from two to five years of age; fifty cases between the ages of five and ten years; and eighteen cases between the ages of ten and fifteen years.

One should always make a diagnosis of epilepsy in a child after every other known cause of convulsions has been ruled out. This should be done by a complete clinical and laboratory investigation, to exclude any evidence of organic disease, cerebral disease, or sources of reflex irritation. Such an investigation should include a blood and spinal fluid Wassermann; blood sugar determination; an examination of the fundi, sinuses, teeth, and tonsils; urinalyses; search of the stools for parasites and ova; and a roentgen ray study of the gastro-intestinal tract for stasis. Generally the examination will be negative throughout, but if there are one or more positive findings of some condition which is amenable to treatment, although a cure may not be affected, the number of attacks may be lessened and the mental deterioration may be considerably delayed.

There has been very little definite advance in our knowledge of the pathogenesis of this condition in many years. The treatment of epilepsy has as its basis, rest, avoidance of mental excitement, an anti-constipation diet, and the sedatives, bromides and pheno-barbital. These drugs should be administered to the point of maximum physiological effect and in the individual case, many times, are of great benefit.

In the last few years a great deal of investigative work has been done on the treatment of epilepsy by starvation, dehydration and the production of ketosis through the administration of a ketogenic diet. The ketogenic diet is one that is composed of a large quantity of fat and, in practice, it amounts to feeding not more than 10-15 grams of carbohydrate and not over one gram of protein per kilogram of body weight, daily, with the remainder of the required calories supplied by fats. A moderate ketosis is produced in a three or four day interval following the institution of such a diet as manifested by the presence of acetone and diacetic acid in the urine and in a large number of cases; although there is a marked individual variation in the effect, the convulsive seizures are stopped or decreased in severity and frequency.

Helmholz and Keith[12], have recently reported their experience with the ketogenic diet in the treatment of epilepsy in children extending over an eight year period and they found that in 141 patients who were treated for more than one year and with whom they had complete cooperation, 43 were cured, 32 were improved, and 66 failed to improve. In other words, 30% were cured and 70% were not.

The difficulties attending this type of therapy are numerous. It is a very unpleasant diet to take and the absence of carbohydrates tends to lessen the appetite and make the patient very unhappy and irritable. Unless the child is in an institution or clinic adapted for this work, or very carefully supervised by cooperative parents, he will steal sugar and sweets, thereby upsetting the balance of the diet, and unless the state of ketosis is constantly maintained over a long period of time attacks will soon recur.

Critics of the diet point out that in addition to the difficulties of preparing and administering such a diet pellagra occasionally develops during the prolonged use of it and also the growth and nutrition of the patient are retarded. Those having had the greatest experience with this therapeutic procedure believe, however, that if the protein and vitamin content of the diet is carefully watched these conditions do not occur.

I believe that in any therapeutic procedure which is completely effective in 30% of the cases and partially so in another 25%, it is certainly worthy of prolonged trial, especially when one is dealing with such a refractory condition as idiopathic epilepsy. It is very important thoroughly to educate the mother or nurse in the preparation of the diet before permitting the patient to leave immediate medical supervision.

The reflex causes of convulsions, I believe, are very much overworked as etiological factors and if one will search long enough and approach the individual case with an open mind, a definite pathological basis will usually be found for the convulsion. The most common reflex causes of convulsions are said to be mechanical irritation of the stomach or intestine from the presence of undigested food, colic, phimosis, trauma of any sort, retention of urine, violent crying, fright, and last but not least, teething and worms.

Teething, in fact, is so frequently the diagnosis in most of the common ailments in infancy, made by both the laity and physicians, that I am forced to repeat the axiom of Chown[13], that, "except for slight refusal of food, some restlessness, a moderate nasopharyngitis and a temperature, never above 101° by rectum, teething produces nothing but teeth."

There are, however, authentic cases in the literature of convulsions ceasing after the passage of several round worms. While this is an exceedingly rare cause of convulsions, a stool examination for parasites and ova is necessary in all cases in which there are no demonstrable findings. I think it good medical practice and fewer errors will be made if we consider teething, worms, phimosis, and all the other reflex causes of convulsions, as incidental rather than as etiological factors.

The immediate treatment of convulsions is directed toward stopping the seizure as soon as possible and in general the different procedures available should be used, progressing from the most simple to the most radical, if the attack remains uncontrolled.

One of the first obligations of the physician to his patient is to see that he is protected from injury, for many times the parents or relatives in their extreme anxiety to do something, injure the child. The simplest measure and the one with which the laity is most familiar is the mustard bath. If the body temperature is not elevated, the temperature of the water should be 105° and brisk friction should be applied to the trunk and extremities. If there is hyperpyrexia associated with the convulsion, a cold bath or pack should be used instead and at the same time a high rectal irrigation should be given. In the average patient, many times, these simple procedures will suffice.

If the attack is a severe one and the child is slow to respond, or passes rapidly from one convulsion to another, magnesium sulphate may be given by rectum or intramuscularly, but if the attack is not controlled by the magnesium sulphate, chloroform should be given in sufficient quantity to check the seizures. Meanwhile sodium bromide and chloral should be given by rectum to prevent the recurrence of the convulsions. The average dose for infants under one year of age is eight to ten grains of sodium bromide and three to five grains of chloral; for older children ten to twenty grains of sodium bromide and five to eight grains of chloral may be given as long as there are any signs of nervous irritability such as twitchings and involuntary muscular contractions. This may be repeated at three to six hour intervals, in diminishing doses.

In cases where chloral and bromide fail to control the convulsions, morphine can be given hypodermically in the appropriate dosage. This is determined by taking the body weight over one hundred and fifty and then multiplying this fraction by the adult dose. This dosage may also be repeated every three to six hours.

After the seizures have been controlled the child should be kept in a quiet, darkened room, with an ice cap to the head. Fluids in the form of orange juice or glucose solutions should be given. A detailed history should then be taken, and a careful examination made, to ascertain the cause.

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BROMIDE THERAPY AND INTOXICATION*

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The bromides are among the most commonly used therapeutic agents in all branches of medicine, yet some of us are unaware of the toxicity of the drug and its potentialities for harm when its use is not carefully controlled by either clinical or laboratory methods. Discovered by Balard in 1826[1] the bromides were actively introduced into therapy by Graf in 1840. Since that time they have been prescribed with increasing frequency, along with the increase in functional nervous disorders accompanying the high pressure living and social maladjustments of modern civilization. Furthermore, a large number of "patent" and proprietary preparations sold over the counter contain as their active ingredient large amounts of bromide. A brief review, therefore, of the essential features of this drug, would seem to be of value.

PHARMACOLOGY

The bromides depress the entire central nervous system with the exception of the medulla. They

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depress the psychic functions, the motor cortex and the spinal cord, lowering its reflex excitability. Excessive use of potassium bromide has produced degeneration of the cortical cells. The action of bromides on the cerebrum is opposed to that of caffeine, and on the spinal cord, to that of strychnine. They lower muscular tone throughout the body. They are only feeble somnifacients but by eliminating worry and anxiety and by allaying nervous excitement they favor the occurrence of sleep. Ordinary doses have no direct effect upon the circulation but large doses depress the heart and vasoconstrictor center. Bromides lessen arterial tension and body temperature, depress sexual appetite and power, cause pallor and emaciation, a coated tongue, disordered digestion, fetid breath, acne on the face and extremities, somnolence, dysphagia, sluggish reflexes and defective coordination. After long continued use there may develop impairment of the mental faculties with hallucinations and delusions, or with melancholia accompanied by suicidal tendency. Maniacal excitement may sometimes arise.

The drug is rapidly absorbed from the gastrointestinal tract but is excreted very slowly, chiefly by way of the kidney, but small amounts leave the body through the skin, saliva, milk, and the intestinal and bronchial mucosa. Hence there is a tendency for the drug to accumulate in the body. When the retention in the blood reaches a certain point, evidences of bromide intoxication or bromism occur.

Therapeutics

Bromides are used chiefly as nerve sedatives. Because of their sedative action on the motor cortex as well as on the afferent paths in the spinal cord they are used to suppress convulsions especially in epilepsy, but also in other convulsive disorders, such as puerperal eclampsia, tetanus, uremia, and strychnine poisoning. In local spasms such as occur in whooping cough, laryngismus stridulus, and bronchial asthma, they may be of service.

In abnormal nervous irritability arising from various causes the bromides find their largest field of usefulness. They are used to allay the unrest resulting from anxiety, worry and overwork, and that accompanying hysteria, the neuroses, and the psycho-neurotic disorders. In the varied nervous disturbances of the menopause and the nervous excitement of hyperthyroidism they are commonly employed. The functional disorders, especially of the heart and gastrointestinal tract, often respond well to their use, and in insomnia resulting from worry and nervous excitement they often produce refreshing sleep.

They are also used as anaphrodisiacs, to prevent seasickness and nervous vomiting, in migraine, neuralgias, nervous headaches and a great variety of other conditions.

Frequency of Intoxication

As a result of the widespread use of this drug, bromide intoxication has become a fairly common syndrome. Doane and Wiener[2] reported four cases on a general medical service in a Philadelphia hospital in 1931. Wagner and Bunbury[3] studied one thousand consecutive cases admitted to the Colorado Psychopathic hospital in regard to their serum bromide content. Of this number 44 cases showed mental symptoms which were due to or increased by bromides. Seventeen of these cases sought admission solely on account of intoxication due to bromides, two of them dying purely from bromism. Both these patients had been taking bromide under the care of a physician and according to the investigators, death could have been prevented had the physician been more familiar with the early symptoms of bromism or willing to make a blood examination. Seventy-seven cases of the thousand showed bromide in concentrations of 75 mg. or over per 100 c. c. of blood. Forty-three per cent of these were receiving the drug on a physician's prescription, eighteen per cent were taking "patent" medicine, and in the remainder the source could not be determined, although the authors believe the drug was obtained in proprietary preparations. Wuth[4] found during a period of six months with 238 admissions to the Phipps Psychiatric Clinic, that fifty cases had considerable bromide in the blood and that twenty cases showed bromide intoxication. Sippe and Bostock[5] in their series collected seven patients who had been taking only moderate doses of bromide and they remark that it is by no means an uncommon factor to be reckoned with in general medical practice and must be watched for continually.

Symptoms of Bromism

The symptoms of intoxication merge gradually with those produced by the therapeutic doses of the drug and are quite variable. The face is dull and expressionless with somnolence of a varying degree. The tongue is coated, the breath fetid and digestive derangements are present. There is muscular weakness, extreme fatigue, loss of energy and disinclination for exertion. The intellectual faculties are depressed and cerebration is slow. There is apathy, impaired memory, inability to concentrate, slow speech and depressed reflexes. The gait is feeble or staggering, with a feeling of drunkenness. There may be incoordination of the hands. The patient may become semi-stuporous with disorientation as to place and time. Swallowing is difficult and sensitivity to touch and pain are diminished. Acne may be present but is not nearly as common as usually supposed. In Wagner and Bunbury's series and in Sippe and Bostock's cases it was rare.

In other cases evidences of mental disturbances develop. There may be hallucinations, and delusions, emotional depression or sometimes acute

maniacal outbursts. In brief, bromide intoxication may present an extremely varied picture.

Mechanisms of Intoxication

The action of bromide is based on chloride—bromide equilibrium or replacement. Sodium chloride constitutes the greater part of the electrolytes of the body and the chloride ion is essential for the function of most cells. The average person ingests from 10 to 20 grams of sodium chloride daily, the excess being excreted by the kidneys. The body maintains its salt concentration remarkably constant. The bromide ion behaves in the body exactly like the chloride ion. When an individual ingests bromide, the total halogens of the body are not increased but the bromides replace the chlorides and an amount of chloride will be excreted equivalent to the amount of bromide ingested. An increase in chloride intake will be followed by a diminution in the amount of bromide retained. When the bromide replaces from 25 to 30 per cent of the chloride of the blood, symptoms of intoxication appear. A replacement of 40 per cent or more is usually fatal. It is evident that the amount of bromide retained in the body and its therapeutic or toxic action will depend both on the bromide and the chloride intake. There is great variation in susceptibility to intoxication in different patients. On the same dosage, the amount of bromide retained will vary. This may be due to a low salt intake from dislike of sodium chloride or in the majority of cases is the result of a poor appetite with a low food intake. Intoxication may occur suddenly though the patient has been taking the drug for months without untoward effects. In anemia, cachexia and dehydrated states in which the body fluids are poor in chlorides, and in kidney and heart disturbances with incidental fluid retention, bromism develops early. Bromides are excreted very slowly by the body. Wuth[4] showed that the excretion of bromides was not completed twenty days after stopping medication. Bromide elimination is even more slowly accomplished in patients suffering with arteriosclerosis and these individuals show a decreased tolerance to the drug. In one of Wuth's cases of intoxication in a man of 59 years, it required 33 days to reduce the blood bromide from 200 to 135 mg. after all medication was stopped.

Bromide Determination in Blood and Urine

With the Wuth comparator,[4] the technic of determining the amount of bromide in the blood is simple. Ten c. c. of the patient's blood is drawn and allowed to coagulate. To 2 c. c. of the serum add 4 c. c. distilled water and 1.2 c. c. of 20 per cent trichloracetic acid. After standing for one-half hour the mixture is filtered. To each c. c. of clear filtrate add 0.2 c. c. of one-half per cent gold chloride solution and compare this solution with the standard color tubes. On the color tubes are figures indicating mg. of sodium bromide per 100 c. c. of serum. For accurate determinations, a colorimeter can be used, but the above method with standard color tubes is sufficiently accurate for practical clinical use.

In the urine Wuth recommends the following test: To 25 c. c. of urine add 1 gram animal charcoal, mix, let stand a few minutes and filter. To 5 c. c. filtrate add 1 c. c. of 20 per cent trichloracetic acid and 1 c. c. ½ per cent gold chloride. A brown shade indicates the presence of bromides.

The optimum concentration of bromide in the blood varies in different patients due to the variation in susceptibility to the drug. Some patients will show toxic symptoms on a relatively low blood concentration while others will occasionally tolerate high concentrations without symptoms of bromism. Age is a definite factor here. Patients over 50 years of age may show toxic symptoms even with low concentrations of bromide in the blood. Chronic alcoholism and syphilis also seem to predispose to intoxications. Wuth says that on the average one should not exceed 125 mg. of bromide per 100 c. c. of blood and that above 150 mg. is the toxic zone. (This represents a replacement of about 20 per cent of blood chloride.) In epilepsy he advises keeping the blood bromide slightly above the level at which convulsions disappear. If convulsions are not controlled at 175-200 mg., he advised against further bromide medication. Wagner and Bunbury[3] from their studies conclude that for practical purposes a concentration of 200 mg. is toxic and that it should be kept below this point. They state that life is endangered at 300 mg.

Treatment of Bromism

The treatment of bromide intoxication is supportive and eliminative. The patient should receive an abundant diet with a large intake of fluids. Diethelm[1] warns against sudden withdrawal of the drug in an intoxication as mood changes occur in the nature of manic excitement or of an outspoken depression. Sodium chloride hastens the elimination of bromide from the body but Wagner and Bunbury advise against its use early after withdrawal of the bromide. It liberates bromides from the tissues faster than the kidney can eliminate them. Consequently the concentration in the blood rises, causing an exacerbation of toxic symptoms which may prove fatal. They recommend waiting until the patient shows signs of improvement and then if the general physical status is satisfactory, sodium chloride in doses of 1.0 to 2.0 grams three times a day by mouth in dilute solution can be given. If oral administration is impractical, it could be given parenterally in the form of normal salt solution. If the patient is debilitated and dehydrated or if the blood bromide is 300 mg. or more, it is inadvisable, according to these investigators, to give sodium chloride until the patient has been built up physically.

Comment

I have observed a number of patients in recent years who have manifested many of the symptoms of bromide intoxication which I have discussed, and who have cleared up slowly on withdrawal of the drug. They have more often been elderly individuals in the arteriosclerotic age, or younger persons who would not take sufficient food and were anemic and undernourished, and I believe that the condition is not uncommon in general medical practice but is apt to be overlooked because we are not sufficiently familiar with the early manifestations of intoxication. May it not be possible that some of the exacerbations of mental symptoms and the psychoses occurring from time to time in patients under our care are due to drug intoxication from our therapeutic efforts rather than to the underlying disease which the patient has?

I do not wish to leave the impression that bromides are harmful and useless as therapeutic agents when properly administered, any more than I would advise against the proper use of digitalis simply because I have seen many cases of digitalis poisoning and several deaths from the drug. The bromides are useful and effective sedatives and are invaluable in many conditions, but they should not be used indiscriminately without appreciating their toxic action and watching the patient for the early symptoms of bromism or making the simple test for determining the concentration of the drug in the blood. One should not wait for skin eruptions as they are more often absent than present in bromide intoxication. We should have some idea of the amount of salt the patient is ingesting and regulate the dose of bromide accordingly. It would seem advisable, if serum tests are not available, to intermit the ingestion of bromides rather frequently, remembering that it takes weeks to eliminate the drug that is stored in the body. And since bromide is a toxic drug, it should be unlawful to sell patented medicines containing this drug over the counter for self medication by patients.

The question of bromide intoxication must be considered in the differential diagnosis of puzzling delirious states and obscure mental conditions. In these cases the qualitative test for bromide in the urine should be done first. If this is negative, bromide intoxication can be ruled out. If positive the quantitative estimation of the blood bromide should be done.

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[3] Wagner, Carl and Bunbury, Elizabeth: Incidence of Bromide Intoxication Among Psychotic Patients, *J. A. M. A.*, 95:1725, December (6), 1930.

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DIFFUSE POLYPOSIS OF THE STOMACH

H. C. Ochsner, M. D.
R. H. Moser, M. D.
Indianapolis

The occurrence of gastric polypi was known to Morgagni, who, however, did not appreciate their true nature. Curveilhier first reported a case in 1833. Menetrier described in detail the condition of multiple gastric polypi, and his most valuable description has been quoted in almost every work on the subject since that time. The first 49 reported cases were recognized only at the autopsy table. In 1909 Wegele reported the first case recognized at operation. Chosrojeff recognized a case in 1912 by finding tumor tissue in gastric lavage. Subsequently two cases have been reported which were recognized by this method; in one of these, polypi were also found in the stool. The first roentgen ray diagnosis was by Carman, to whom Balfour accredited the discovery of multiple gastric polypi in a case he reported in 1919. Schindler reported the recognition of a case by gastroscopy in 1922.

There are numerous types of benign gastric tumors—among them the leiomyoma, fibromyoma, adenomyoma, simple myoma, hemangioma, and polyp or adenoma. There are three types of gastric polypi: the single polypoid tumor, polyadenoma of the "Brunnerian" type, and polyadenoma as described by Menetrier. The latter described two types of polyposis: the "polyadenomes polypeux" and "polyadenomes en nappe." In the former, more common type, there is a large number of discrete polypi scattered over a large area of the stomach wall, whereas in the latter there is a large number of polypi closely aggregated on a sort of plaque-like base. The etiology of the condition is problematical, and various observers have considered it congenital or due to inflammation or chronic irritation; it may be produced experimentally by the injection of coal tar into the stomach of the rabbit.

Multiple gastric polypi are found somewhat more frequently in males than in females, although the sex incidence as reported by many observers is almost identical. The condition is probably not so rare as was formerly supposed; Carmen found only two cases in fifty thousand x-ray examinations of the stomach, but Kirklin has recently reported seventeen more, and there is a rapidly increasing number of case reports in the literature. It is the recent perfection of x-ray examination of the stomach that has been largely responsible for the increasing recognition of the condition. Although gastric polyposis may occur in childhood (Moore reported a case in a child of eight), the greatest incidence is from the fourth to the seventh decades. Rosenbach and Disqué found that 83.6 per cent of 112 cases fell in the age groups 40 to 90, and that the greatest incidence was in the sixth decade.

The clinical manifestations are varied, and often not characteristic; they may extend over a period of years, or only a few months. Probably the most constant symptom is epigastric pain, which may vary from an indefinite distress to a burning, cramp-like pain. Next in frequency is hemorrhage, which may be manifested either as hematemesis or melena; depending upon the duration of these symptoms there is a variable degree of anemia. Death from severe acute hemorrhage rarely occurs. Anorexia is a frequent manifestation, and in consequence there is loss of weight and strength. The presence of a palpable mass is rarely recorded, except when malignant degeneration has occurred. Pyloric obstruction may be found if there is a similar involvement of the duodenum, or if there is prolapse of a portion of the gastric tumor through the pylorus; in the latter event the obstruction may be intermittent. Vomiting may be a symptom, and the vomitus often contains a characteristic glairy mucus similar in appearance to egg white. Constipation is often reported, but diarrhea not infrequently occurs secondary to the achlorhydria, which is almost constantly present.

In benign gastric tumors, other than diffuse polyposis, the gastric acidity may be normal or increased; but in this condition free hydrochloric acid is almost never demonstrated in the gastric content. An abundance of the characteristic egg white mucus is often found. The most valuable laboratory finding in diffuse polyposis is seen after administration of a barium meal. As the stomach is filled, the "magenstrassen" are seen to be markedly accentuated, and there are irregularly rounded transradiant areas within the barium shadow. With the stomach completely filled, there are multiple indentations along one or both curvatures, and it is only by the application of pressure to approximate the anterior and posterior walls that the true appearance is observed, and the rounded excrescences projecting from the stomach walls are well visualized. Usually gastric motility is normal, and peristalsis is uninterrupted. Although the x-ray findings are so characteristic, one must be careful to exclude retained food or phytobezoar, either of which may produce a somewhat similar picture. Confusing findings may also be produced by a simple hypertrophy of the rugae, the pressure of a gas-filled colon, or by polypoid carcinoma. A coincidental polyposis or adenomatosis of the rest of the gastro-intestinal tract has never been observed, but in several reported cases —as well as in our Case No. 1—an involvement of the duodenum has accompanied the gastric lesion.

Although there is disagreement among various observers in regard to the tendency to malignant degeneration of these tumors, the possibility that such a change may occur must be borne in mind. As a consequence, if surgery is permitted, radical measures must be instituted to eradicate the entire growth, if this is possible. This is manifestly difficult in the "polyadenomes polypeux" type, but may be feasible in the case of "polyadenomes en nappe." Palliation of the pain and hemorrhage may be accomplished by the judicious application of short wave roentgen rays. Brunn and Pearl reported improvement in one case following this method of treatment, and Struthers reported a case with relief from all symptoms for three months. In our Case No. 1 this treatment was used, with some improvement.

CASE I. Mr. J. D. White, male, age 63. Admitted to the hospital on March 15, 1932; discharged April 4, 1932.

The patient's chief complaints were weakness of ten days' duration; sour, gaseous eructations and occasional "hunger pains" occurring often at night for several months; constipation, with tarry stools the past ten days; and five pounds weight loss. He stated that he had always been somewhat troubled with belching. His history was otherwise essentially negative, and physical examination was negative except for a lemon-yellow pallor. No masses were palpable in the abdomen. The hemoglobin on admission was 57 per cent, with 2.75 million erythrocytes. The leucocyte count was 7,600, with 69 per cent polymorphonuclears. Bleeding time was five minutes. Urinalysis was negative, but the stool showed a positive benzidine reaction on admission and during the entire period of hospitalization. The Ewald meal revealed no free hydrochloric acid, and the combined acidity was 10 per cent. Lactic acid, blood, and Oppler-Boaz bacilli were present. There was also noted an abundance of glairy mucus.

X-ray examination revealed the chest, colon, and gall bladder to be essentially negative. Throughout the stomach were seen multitudes of large and small rounded filling defects; there were also similar defects in the first and second portions of the duodenum. Gastric peristalsis was diminished, and a 70 per cent gastric retention was found six hours after administration of the meal. Some barium was still visualized in the stomach at the end of twenty-four hours. A diagnosis was made of diffuse polyposis of the stomach and duodenum. No definite evidence of malignant change could be demonstrated. Operation was refused, and conservative treatment was instituted. Two transfusions were given, and several exposures of short wave roentgen therapy were administered to the region of the stomach. The patient showed some clinical improvement, and the blood picture improved. The hemoglobin at the time of dismissal was 66 per cent and the erythrocyte count was 3.6 million. The patient was permitted to return home, and remained fairly well for several weeks, but died three months after dismissal. Autopsy was refused.

(Continued on page 494)



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President Indiana State Medical Association, 1933



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THE FRENCH LICK SESSION

In September the Orange County and the Third District Medical Societies will have the distinction and honor of being hosts to the Indiana State Medical Association, at its 86th annual session. An unusual round of entertainment and a splendid scientific program is promised. One of the unique features of the meeting is that everything will be under one roof, the French Lick Springs Hotel. French Lick is renowned the world over as a health and pleasure resort.

Early History of French Lick

The earliest written record of French Lick was by General George Rogers Clark, who in his memoirs of the famed expedition to Kaskaskia and Vincennes, speaks of it as "a great resort for deer and buffaloes, and that their unusual tameness was a strong indication that they had been but little hunted here." There was a trading post established by the French, and tradition has it a settlement in the eighteenth century. The settlement was supposed to have been for the manufacture of salt, but because of the hostility of the Indians, it was soon broken up. Among the early settlers the Springs became known as the "Lick," from the fact that the deer and other animals frequented the place for the salty waters; hence it is easy to see from where the name French Lick was derived.



George Dillinger
Chairman Committee on Arrangements

The first permanent settlement was made at French Lick about 1811, and at about the same time a fort was established and garrisoned by the government for several years. This fort was located on the grounds of the French Lick Springs Hotel. By 1817 the population had increased until there were 24 men of voting age and it was felt that a civil form of government should be established and the first justice of the peace was elected.

It was said by the Indians that silver and lead in unlimited quantities were to be found in the caves and mines about French Lick. Because of friction between the Indians and the white settlers, the Indians were careful to conceal this reputed wealth, and when they left the country the secret went with them. About 1850 interest was renewed by the appearance of two strangers who claimed to have come from Canada, where they had secured from an old Indian squaw, a former resident of the French Lick region, directions for finding silver and lead in a cave about three miles from French Lick. So pure was the metal, according to the squaw, that the Indians had chopped it out with tomahawks. Excitement was intense and men from all about joined in the search, but to no avail. Either the metals were a myth of the Indians, or the secret had been carried away with them for all time.

It was at first felt that the land surrounding the Springs could be utilized for making salt, and at the first surveying, twelve sections were set aside for that purpose. In 1829, after boring a 200-foot well and finding nothing of value, the state legislature petitioned the Congress of the United States for permission to sell the land in fee simple. This petition was granted and at public sale the land surrounding the Springs was sold to William A. Bowles, a physician, statesman, and soldier.

Dr. Bowles built the first hotel at the Springs prior to 1840. It was an ungainly frame building, but the fame of the waters at French Lick soon became widely known and the hotel was well patronized. Guests at the hotel came and went in creaking wagons and it was a common sight to see the home-going wagons laden not only with luggage and human freight, but with jugs and containers of various sorts filled with quantities of the waters with which the visitors could continue their treatment at home. Later the doctor conceived the idea of boiling down the water, so that his guests might carry away larger quantities in smaller packages. This was an immediate success. In 1846, Dr. John A. Lane leased the Springs from Dr. Bowles for a period of five years, and at the end of that time, because of friction between the two, Dr. Lone purchased the land and started West Baden Springs. The French Lick Springs were rented in 1864 by Dr. Samuel Ryan for a period of 15 years. By 1880 an average of over 7,000 persons per year were visiting French Lick for their health. After the death of Dr. Bowles, in 1873, the Springs passed into the hands of Dr. Samuel Ryan and others, and still later into the hands of Dr. John Howard, who came from Jeffersonville. About the beginning of the present century the Springs passed into the hands of the present corporation, and under the guiding hand of the late Senator Thomas Taggart, grew to be the famous resort that it is today.



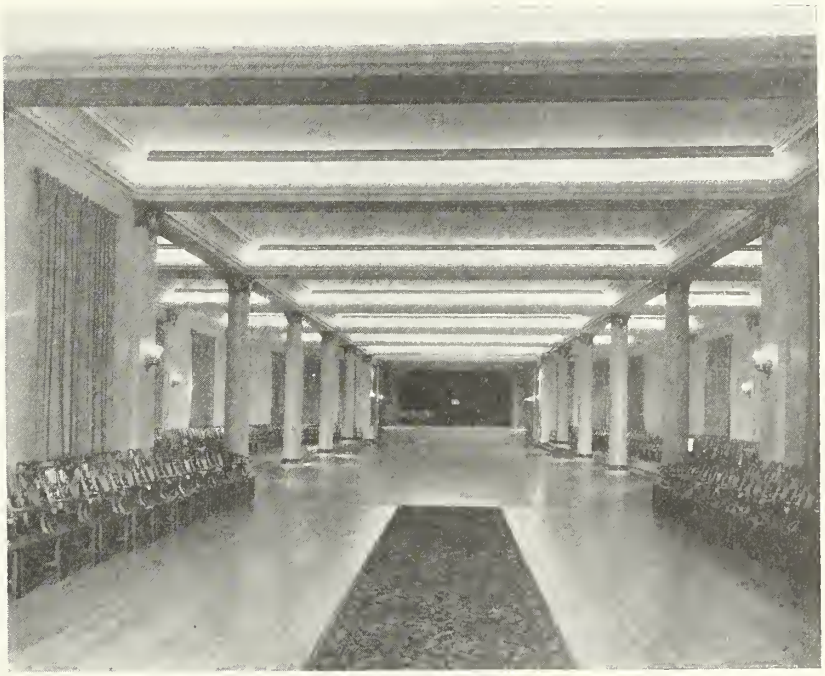
French Lick Springs Hotel



The Japanese Garden—French Lick Springs Hotel

THE ORANGE COUNTY MEDICAL SOCIETY

The first organization of a medical society in this community was effected in the autumn of 1852, the first meeting being held at the office of Dr. Pearson, in Paoli. The officers elected were: Dr. Pearson, president; Dr. Hazelwood, vice-president; Dr. Hoover, secretary; Drs. Reily, Botsell and W. F. Sherrod, censors. The physicians present were: Lee, Hazelwood, Botsell, W. F. Sherrod, J. H. Sherrod, C. D. Pearson, C. L. Hoover and Dr. McCann. Dr. W. F. Sherrod was appointed to deliver an address on some medical subject at the next meeting. A constitution and by-laws were adopted; also a code of ethics and a bill of charges. This society soon died, and no trace of other meetings have been found. In October, 1875, another society, a branch of the State Association, was organized, the first members being John A. Ritter, U. H. Hon, Benton J. Hon, T. P. Carter, Laban Lindley, E. D. Laughlin, John A. Cole and James Dillard, and later R. W. Lingle, Henry Lingle, R. D. Walters, G. W. Burton, and C. E. Laughlin. The first officers were: John A. Ritter, president; E. D. Laughlin, vice-president; John A. Cole, secretary; B. J. Hon, treasurer; T. P. Carter, B. J. Hon and E. D. Laughlin, censors. This organization has continued with more or less regularity to the present time.



Main Assembly Hall, French Lick Springs Hotel



The Trap Shoot—French Lick Springs Hotel

POINTS OF INTEREST

French Lick is located in the scenic hills of Southern Indiana, and is surrounded by many points of interest. In Lawrence County, near Bedford, are situated the largest quarries of building stone in the world. Corydon, the old state capital, with its restored buildings, is only a short drive. There are numerous caves in the neighborhood, the more famous being Wyandotte and Marengo. The Orange County Courthouse at Paoli, built in 1847, was considered the best in architecture at that time. Near Mitchell is located Spring Mill State Park, which has been restored to its condition of a century ago, and it is indeed worth seeing. The rise of Lost River at Orangeville is of interest to many.

PLACE OF MEETING

All meetings will be at the French Lick Springs Hotel. The hotel property covers 4,000 acres of ground, and a good part of the products used in the dining room are produced on this acreage. A model dairy farm is operated, where a registered herd, electrically milked,



French Lick Springs Golf Club

produces all the creamery products. Ice cream is manufactured at the dairy. Most of the pork, veal, poultry, eggs, and vegetables come from the farms.

The hotel itself, seven stories high, has seven hundred rooms and contains more than 25 acres of floor space, and is of fireproof construction. The main convention hall seats 1,500 people and is especially built for convention purposes. Smaller halls seat 200 and 400. Every facility is present for a most successful meeting.

The hotel is operated on the American plan so that when you pay the hotel charges, there is no other expense. The meals that you eat at French Lick will be remembered with pleasure.



Pluto Spring Pavilion

Golf and Sports

French Lick is a golfers' paradise, for there are two eighteen-hole courses operated in connection with the hotel. The courses are kept in the best of condition, and are among the best in the country for tournament play. A nine hole pitch-and-putt course is available.

Tennis courts, swimming pools, miles of bridle paths, horse shoe pitching courts, shady trails for hikers, and baseball diamonds are usable.

Traps are available and we hope to have a good turnout for the new event, Trap Shooting. Anyone who enjoys hunting will get a thrill out of seeing the clay pigeons shatter in mid-air.

Routes

The Monon, Southern and Baltimore and Ohio railroads reach French Lick. U. S. Highway No. 150 and Indiana highways No. 37 and No. 56 are the automobile routes.

Entertainment

The entertainment is going to be outstanding and none will want to miss any of it. The stag on Monday evening is being given to the physicians by the French Lick Springs Hotel Company. We are not putting out any advance information, but it is going to be *some party.* On Tuesday evening the fraternities and the Veterans are having their annual get-togethers, followed by a theatre party, dancing and cards. On Wednesday evening comes the big banquet, and if you have never attended a banquet at French Lick—well "You Ain't Seen Nothin' Yet!"

The ladies are all set for a big round of pleasure, starting Monday afternoon, and they are going to be having fun every minute of their stay. A mystery field day, a dinner and reception with lots of entertainment and fun starts it off on Monday. Tuesday, the Auxiliary Breakfast, a trip through the Pluto Plant, an auto ride and tea at Spring Mill, dinner, theatre party, dancing and cards will keep them busy. On Wednesday there will be a morning party, luncheon and bridge at the club house.

Think it over. Can you afford to miss the French Lick meeting? Think again; think of all the good times that are waiting for you; and don't forget your wife.

See You at **French Lick!**



Scene of Grounds at French Lick Springs Hotel

OFFICIAL CALL TO THE HOUSE OF DELEGATES

The next annual session of the Indiana State Medical Association will be held at French Lick, September 25, 26 and 27, 1933.

The House of Delegates will be constituted as follows: Marion County, nine delegates; Lake County, three delegates; Allen County, two delegates; St. Joseph County, two delegates; Tippecanoe County, two delegates; Vanderburgh County, two delegates; Vigo County, two delegates; the other seventy-five county societies, each one delegate; thirteen councilors; the ex-presidents, namely, C. S. Bond, M. F. Porter, W. N. Wishard, J. C. Sexton, G. W. McCaskey, J. B. Berteling, Joseph R. Eastman, W. H. Stemm, C. H. McCully, W. R. Davidson, E. M. Shanklin, Charles N. Combs, Frank W. Cregor, George R. Daniels, Charles E. Gillespie, Angus C. McDonald, A. B. Graham, and F. S. Crockett. In addition to these, the president, secretary, and treasurer, all without power to vote except in case of a tie, when the president shall cast the deciding vote.

Blank credentials have been sent by the secretary to each county society, and the properly executed credentials should be mailed to Thomas A. Hendricks, 1021 Hume-Mansur Building, Indianapolis, or brought to the session. No delegate will be seated unless wearing the official badge.

The House of Delegates will convene promptly at 4:00 p. m. Monday, September 25th, in the convention hall, convention building, and again at 7:00 a. m. Wednesday morning, September 27th, in the west dining room, French Lick Springs Hotel (breakfast meeting).

The order of business will be as follows:

1. Call to order by the president.
2. Roll call and seating of qualified delegates.
3. Reading of the minutes of previous meetings.
4. Appointment of reference committees.
5. Report of the executive secretary.
6. Report of the treasurer.
7. Report of the chairman of the council.
8. Reports of standing and special committees:
 a. Credentials.
 b. Executive.
 c. Public Policy and Legislation.
 d. Journal Publication Committee.
 e. Bureau of Publicity.
 f. Medical Education and Hospitals.
 g. Civic and Industrial Relations.
 h. Scientific Work.
 i. Registration.
 j. Necrology.
 k. Postgraduate Study.
 l. Study of Health Insurance.
 m. Delegates to the A. M. A.
 n. Veterans' Hospitalization.
 o. Business Instructional Course.
 p. Study of High School Athletics.
 q. Public Relations.
 r. Lye Burns in Children.
 s. Special Medical Defense Fund.
 t. Medical Care of the Indigent.
 u. Study of Puerperal Mortality.
 v. Arrangements.
 w. Diphtheria.
 x. Secretaries' Conference.
9. Reading of Communications.
10. Reading of memorials and resolutions.
11. Unfinished business.
12. New Business.
13. Adjournment.

The election of officers will be the first order of business at the second meeting of the House of Delegates. In addition to the regular officers, the terms of the following officers expire December 31, 1933, and their successors must be elected at the session: Delegates to the American Medical Association to succeed Don F. Cameron, Fort Wayne, and F. S. Crockett, Lafayette, and alternates, W. F. Carver, Albion, and G. D. Scott, Sullivan.

Delegates from the second, fifth, eighth, and eleventh districts are reminded that the terms of their councilors will expire December 31, 1933, and new councilors should be elected to succeed the following:

Second District: H. C. Wadsworth, Washington.
Fifth District: O. O. Alexander, Terre Haute.
Eighth District: M. A. Austin, Anderson.
Eleventh District: E. O. Harrold, Marion.

Some of these elections already may have been held but they should be reported to the House of Delegates at this session for confirmation.

THOMAS A. HENDRICKS,
Executive Secretary.

ANNOUNCEMENTS

ALL members and those accompanying them are requested to register upon arrival. The registration desk will be located in the exhibit hall, convention building, French Lick Springs Hotel.

MEMBERS of the House of Delegates are reminded that the first meeting of the House will be held at four o'clock in the afternoon, Monday, September 25th, in the convention hall of the French Lick Springs Hotel.

WEAR the official badge which you will receive when you register.

PLEASE have your pocket cards with you, to avoid delay in registration. If you have paid your dues only recently and have not yet received your membership card, present a receipt from your county secretary and you will be permitted to register.

ESSAYISTS: Please remember that all papers presented before the session of the Association be-

come the property of the Association and, therefore, are not to be published or submitted for publication elsewhere than in THE JOURNAL of the Indiana State Medical Association.

Registration desk will be in the exhibit hall of the French Lick Springs Hotel. Register immediately upon your arrival.

COUNCILORS will have a luncheon meeting in the special dining room of the French Lick Springs Hotel, at 12:30 p. m., Monday, September 25th.

A STAG dinner and entertainment—compliments of the French Lick Springs Hotel Company—will claim the attention of the men on Monday evening, at seven o'clock, in the basement of the convention building.

THE Woman's Auxiliary to the Indiana State Medical Association will meet in the west dining room of the French Lick Springs Hotel for a breakfast and business meeting, Tuesday morning, September 26th.

There will be a meeting of laboratory men of the state at the time of the French Lick meeting. Time and place will be announced in the printed programs for the French Lick session.

FRATERNITY and class get-togethers, and ex-service men's dinners will occupy Tuesday evening.

TUESDAY evening at nine o'clock: a theater party for physicians, their wives and guests, in the main convention hall of the French Lick Springs Hotel; at ten-thirty there will be informal dancing and cards.

All events of entertainment for women are for all women attendants at the convention, whether or not they are Auxiliary members. All attending ladies are cordially invited and urged to participate in the diversions provided.

THE annual banquet will be served in the main dining room of the French Lick Springs Hotel. Dr. Walter Bierring, president-elect of the American Medical Association, and Dr. Morris Fishbein will be the principal speakers.

LADIES! You will not want to miss the dinner party and pageant-lecture on Monday evening, September 25th, at 7:00 o'clock. Mrs. Minna Schmidt's "Romance of the Bridal Dress Through the Ages" has been enthusiastically received in other places, and we know that you will enjoy the presentation.

FOR THE LADIES!

THE ladies will be unusually well entertained at the convention this year. The program starts at three o'clock Monday afternoon, with a bit of fun, "Mystery Field Day," where the ladies will compete with the doctors. No one will want to miss this, for there will be loads of fun in store for everyone, spectators as well as participants. Interesting events! Handsome prizes! The dinner party on Monday evening promises to be a very lovely event. At this dinner, Minna Moscherosch Schmidt, LL.B., LL.M., lecturer and director of the Costume Workshop at the University of Chicago, will present her pageant, "The Romance of the Bridal Dress Through the Ages," with thirty-three models. Mrs. Schmidt has spent a great deal of time and study abroad securing these costumes, all of which are authentic. Perhaps you will remember having seen Mrs. Schmidt's figurines of the Four Hundred Outstanding Women of the World and the Costumology of Their Time in the General Exhibition Building at the Century of Progress. An informal reception, where the ladies can meet and visit with each other, will be given on the mezzanine floor immediately following the dinner.



Tuesday will be a full day with the Auxiliary breakfast, the inspection of the Pluto Bottling Plant in the forenoon, and the trip to Spring Mill State Park in the afternoon. At one-thirty the ladies will be taken for a delightful automobile trip through the beautiful hills of Southern Indiana to Spring Mill State Park in Lawrence County. After a short drive through the Park, the ladies will be taken to the village where Mr. E. Y. Guernsey, historian of the Department of Conservation, will give the historical background and facts concerning the restoration. There will be leisure time for inspection of the buildings and tea will be served at the Tavern before returning to the Hotel at French Lick.

Tuesday evening the ladies will join the physicians for the theater party and "general get-together."

An enjoyable day is planned at the Golf Club on Wednesday. The ladies will leave for the club at ten-thirty where Kathryn Turney Garten will re-

view books from the latest fall publication. Luncheon will be served at twelve-thirty and will be followed by a bridge party.

The big house party will come to a fitting close with the elaborate banquet, Wednesday evening, at the French Lick Springs Hotel.

FRATERNITY GROUPS

At the coming session of our Association every effort will be made to provide opportunity for the men to renew old acquaintances. With this idea in mind, a committee was appointed, and this committee has arranged for a meeting of each of the fraternity groups: Nu Sigma Nu, Phi Rho Sigma, Phi Beta Pi, Theta Kappa Psi, and Phi Chi. Also, there will be a meeting of the ex-service men, although this will not be under the direction of the committee.

Meetings of these organizations will be Tuesday evening, at six-thirty. Dr. Ralph Ploughe will be toastmaster for the Phi Beta Pi; Dr. J. H. Warvel will be toastmaster for the Phi Rho Sigmas; Dr. Bert Ellis will be in charge of the Phi Chi meeting; Dr. Everett Williams will preside for the Theta Kappa Psi; and Dr. E. N. Kime will have charge of the Nu Sigma Nu group.

There will be NO charge for any regular meals for those registered at the French Lick Springs Hotel. All persons not registered at the Hotel will pay regular rates for breakfast ($1.00); luncheon ($1.50); dinner ($1.50); and banquet ($2.00). This includes the golfer's luncheon, the Auxiliary breakfast, Council luncheon, fraternity and ex-service men's dinners, women physicians' dinner, House of Delegates breakfast, the annual banquet, etc. THERE WILL BE NO CHARGE FOR THE STAG DINNER; IT WILL BE ABSOLUTELY FREE TO EVERY MEMBER OF THE INDIANA STATE MEDICAL ASSOCIATION.

All visiting organized men are urged to keep this date, Tuesday evening, September 26th, open, and meet with their respective groups. Those who are registered at the French Lick Springs Hotel will be admitted to the banquets free. For those who are not registered at the hotel there will be a charge. There will be a program of entertainment for the women at this time, so that you may rest assured that your wife will be entertained while you are enjoying yourself with your fraternity brothers.

R. B. SMALLWOOD, Chairman.
F. M. APPLEGATE.
MARVIN MCCLAIN.

WOMAN physicians will have a dinner meeting at six-thirty, Tuesday evening, September 26th. Alice Pickett, M. D., assistant professor of obstetrics at the University of Louisville School of Medicine, Louisville, Kentucky, will be the principal speaker.

HOTELS

French Lick Springs Hotel, with meals included and all entertainment, has 48 rooms (accommodations for 96 people), with running water only, at $5.00 per day; it has 608 rooms at $6.00, $7.00, $8.00, and $9.00 per day, the six and seven dollar

(Continued on page 441)

French Lick, Indiana,
August 20, 1933.

Dr. George Dillinger,
French Lick, Indiana.

Dear Doctor:

After our meeting last evening it occurred to me that the reference to rates at French Lick had probably been made without a full knowledge of what the French Lick rates include. To the unthinking person French Lick's rates will always suffer by comparison with city hotels, which latter rates are for lodging only.

The rates quoted for the Indiana State Medical Association Convention at French Lick Springs Hotel next month include, besides the rooms or lodgings, ALL MEALS and the following items which would be extra charges in city convention hotels:

Greens fees on golf course,
The use of tennis courts,
The use of 9-hole pitch and putt course,
The use of 9-hole indoor golf course,
The services of our orchestra throughout your convention,
Dancing in the lobby every night,
The use of swimming pools,
The annual banquet,
The use of convention halls,
The use of exhibit space,
The use of committee rooms,
The use of private dining rooms.

At all other points either your delegates or your Association must pay charges for these privileges or facilities listed above, all of which are included in the low rates you are asked to pay at French Lick.

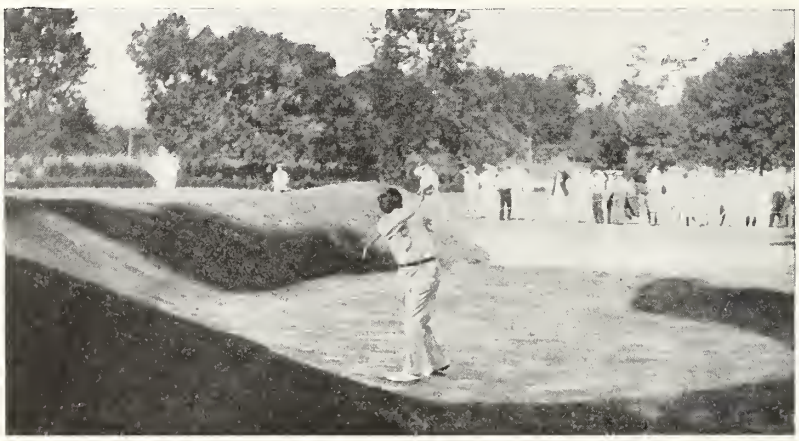
As all of the convention facilities at French Lick Springs Hotel are under one roof you have no taxicab bills to pay and it is a matter of record in the public prints that many national organizations meeting here have found their expenses for both the delegates and the association to be less at French Lick Springs than they are at many other points not having the reputation or the conveniences and comforts of this establishment.

As to the fact that a $7.00 rate has been named for rooms with bath at French Lick Springs, that is true, but this rate applies only to our Summer and Winter Seasons and this rate was instituted in connection with railroad excursions. At the season of the year during which your convention is held our rates for our regular guests range from $8.00 to $20.00 per day per person, so that you will see that in quoting rates for your convention of $5.00 to $9.00 per day a very substantial reduction has been given the Indiana State Medical Association.

In conclusion I might add that as you and your local committee know, in addition to the facilities offered by the hotel and included in the rates, Mr. Taggart is giving your annual stag and also the ladies' bridge party at the French Lick Springs Golf Club with his compliments, and without any expense to your organization.

Yours sincerely,
FRENCH LICK SPRINGS HOTEL CO.
H. J. Fawcett, Manager.

ATTENTION, GOLFERS!



Elaborate preparations are being made to make this year's golf tournament the best in the history of the Indiana State Medical Association.

The tournament and golf luncheon will be held Monday, September 25th, on the famous French Lick Hill course. Donald Ross, one of America's foremost golf architects, designed this course to be the outstanding test of golf in the midwest. It has been the scene of many tournaments, including the National P. G. A., and the playground of practically every internationally famous golfer. Situated in the rolling hills of southern Indiana, the course presents a scenic and landscaping effect that is seldom equalled. Its rolling fairways, beautiful greens, creeks, woodland and more than ninety sand traps, make it a real test for the par shooter and a thrill and inspiration for the dub.

Dr. H. B. Shacklett, of New Albany, is chairman of the golf tournament. Dr. Augustus P. Hauss, of New Albany, is the secretary, and will be assisted by Drs. C. E. Stouder and A. E. Newland, of Bedford, and Dr. W. A. Hall of New Albany.

This committee is planning a tournament that should attract every golfing medic in the state. There will be numerous trophies for both low gross and low net, and will be arranged so that every entrant, regardless of playing ability, will have a chance to win a trophy.

Anticipating many out-of-state guests, the committee has planned a special trophy for convention guests who do not reside in Indiana.

The committee has adopted the following tournament rules:

1. The tournament will be open to all members of the Indiana State Medical Association.
2. Guests from other states will only be eligible for the special out-of-state trophy.
3. No entrance fee will be charged any tournament entrant.
4. Registered guests at the French Lick Springs Hotel will be furnished a free green fee ticket by applying at the hotel office.
5. Entrants not registered at the French Lick Springs Hotel will be required to pay a specially reduced green fee of $1.00.
6. Entrants to the golf tournament are requested to file entry blank with tournament committee's secretary not later than Saturday night, September 23rd.
7. Each entrant must file with his entry blank a record of his home club handicap as of September 1st, and attested by his club secretary.
8. Entrants who do not furnish an attested home club handicap are required to furnish attested scores of at least five recent eighteen-hole games.
9. Tournament play will start at 9 a. m., Monday, September 25th.
10. All other entrants will be required to play scratch.
11. You are requested to fill in and mail at once this entry blank.

GOLF TOURNAMENT
ENTRY BLANK

Dr. Augustus P. Hauss, Secy.,
Golf Tournament Committee,
Indiana State Medical Association,
212 Elsby Bldg.,
New Albany, Indiana.

Enter Name

Address

Home Club Handicap

Attested by**Secy.**

Name of Home Club

HOTELS

(Continued from page 439)

rooms having private toilet and running water, the eight and nine dollar rooms having running water, toilet and bath. These prices *include meals.*

The Homestead Hotel, in West Baden, offers the following:

Rooms with	Single	Double
Running water only	$1.50	$2.50
Running water and toilet	2.00	3.50
Running water, toilet and bath	2.50	$4-$5

The Sullivan Hotel at West Baden:

Running water	$1.00	$1.50
Running water and bath	1.50	2.50

These rates do not include any meals.

Other smaller hotels, rooming houses and private homes are available if desired.

CONDENSED PROGRAM

All meetings will be held at the French Lick Springs Hotel, convention headquarters

(Schedule to be carried out on central standard time.)

Monday, September 25, 1933

Morning

8 a. m. to 6 p. m. Registration in exhibit hall, convention building, French Lick Springs Hotel, convention headquarters.

8 a. m. to 6 p. m. Opening of scientific and commercial exhibits in exhibit hall, convention building.

9:00 a. m. Annual golf tournament. Eighteen holes, low gross and handicap medal play, French Lick Springs Country Club. (No greens fees for headquarters hotel guests. Golfers pay own caddie fees.)

9:00 a. m. Golf for women who choose. (Women wishing to play golf at any time during the convention will please procure free tickets at the convention registration desk.)

Noon

12:15 p. m. Golfers' luncheon, special dining room, French Lick Springs Hotel.

12:30 p. m. Council luncheon meeting, special dining room, French Lick Springs Hotel.

Afternoon

1:30 p. m. Trap shoot for men, Dry Hollow, French Lick Springs Hotel.

3:00 p. m. Mystery Field Day with events for women as well as men. Handsome prizes! Do not miss this event! East of eighteenth green, Hotel golf course.

4:00 p. m. Meeting of the House of Delegates, convention hall, convention building, French Lick Springs Hotel.

Evening

7:00 p. m. Stag dinner and entertainment, basement of convention building. (Compliments of French Lick Springs Hotel Company.)

7:00 p. m. Dinner party and entertainment for women, west dining room, French Lick Springs Hotel, followed by informal reception, mezzanine floor.

Tuesday, September 26, 1933

Morning

8 a. m. to 6 p. m. Registration continues.

8 a. m. to 6 p. m. Scientific and commercial exhibits, exhibit hall, convention building, French Lick Springs Hotel.

8:30 a. m. Breakfast and annual business meeting, Woman's Auxiliary to the Indiana State Medical Association, west dining room, French Lick Springs Hotel.

9 to 12 m. Instructional courses in convention building, French Lick Springs Hotel. The scientific program for this morning is divided into three instructional courses dealing with problems faced by men doing general practice, to be conducted by each of the three sections:

Medical Section, main convention hall, convention building.

Surgical Section, north room, convention building.

Section on Ophthalmology and Otolaryngology, basement of convention hall, convention building.

10:30 a. m. Trip for women through Pluto Bottling Plant at French Lick Springs Hotel. Women will assemble on Hotel porch.

Noon

12 m. Luncheon for all women going to Spring Mill State Park, main dining room, French Lick Spring Hotel.

Afternoon

12:15 to 2 p. m. Economic round table discussion. Luncheon meeting, west dining room, French Lick Springs Hotel. E. E. Padgett, M. D., Indianapolis, president-elect, leading. At this luncheon subjects of economic interest are to be discussed. Governor Paul V. McNutt will be the guest of honor.

1:30 to 4 p. m. Automobile trip to Spring Mill State Park (about 6 miles east of Mitchell, Ind., Lawrence County. Assembly at front entrance of hotel. Historical talk and tea.

2 to 5:30 p. m. First general session and scientific meeting, convention hall, convention building.

EVENING

6:30 p. m. Fraternity, class and ex-service men's dinners, get-togethers and banquets, in various dining rooms, French Lick Springs Hotel.

6:30 p. m. Dinner for women physicians. Alice Pickett, M. D., Louisville, speaker.

9:00 p. m. Theater party for physicians, their wives and guests, main convention hall, convention building, French Lick Springs Hotel.

10:30 p. m. Informal dance in hotel lobby. Cards and general get-together, mezzanine floor.

Wednesday, September 27, 1933

MORNING

7:00 a. m. House of Delegates breakfast meeting, west dining room, French Lick Springs Hotel. Annual election of officers and selection of convention city for 1934.
Meeting of Council immediately following adjournment of House of Delegates, French Lick Springs Hotel.

8 a. m. to 6 p. m. Registration continues.

8 a. m. to 6 p. m. Scientific and commercial exhibits, exhibit hall, convention building, French Lick Springs Hotel.

9 to 12 m. Scientific program—section meetings:
Medical Section, main convention hall, convention building.
Surgical Section, north room, convention building.
Section on Ophthalmology and Otolaryngology, basement of convention building.

10:30 a. m. Program for women, French Lick Springs Golf Club. Women will assemble at main entrance of hotel for cars to the Golf Club.

NOON

12:30 p. m. Luncheon bridge for women, French Lick Springs Golf Club. (Luncheon compliments of French Lick Springs Hotel.)

AFTERNOON

2 to 5 p. m. General scientific meeting, main convention hall, convention building. This is to be the big scientific meeting of the convention, a scientific program of interest to the man in general practice. Upon this program are surgeons and internists of national reputation.

EVENING

7:00 p. m. Annual banquet, main dining room, French Lick Springs Hotel. Principal speakers, Walter L. Bierring, M. D., Des Moines, Iowa, president-elect, American Medical Association, and Morris Fishbein, M. D., Chicago, editor of *The Journal of the American Medical Association.*
Dancing in main lobby of hotel until midnight.

PROGRAM FOR WOMEN'S ENTERTAINMENT AND WOMAN'S AUXILIARY TO THE INDIANA STATE MEDICAL ASSOCIATION

Monday, September 25, 1933

9:00 a. m. Golf for those who choose. (Ladies wishing to play golf at any time during the convention will please procure free tickets at the convention registration desk.)

3:00 p. m. Mystery Field Day with events for both women and men. Handsome prizes! Do not miss this event! East of eighteenth green, Hotel golf course.

7:00 p. m. Dinner party and pageant-lecture, Mrs. Minna Schmidt, "Romance of the Bridal Dress Through the Ages," west dining room, French Lick Springs Hotel, followed by informal reception, mezzanine floor.

Tuesday, September 26, 1933

8:30 a. m. Breakfast and annual business meeting, Woman's Auxiliary to the Indiana State Medical Association, west dining room, French Lick Springs Hotel.
Program:
Mrs. Charles F. Voyles, Indianapolis, president.

1. Invocation—Mrs. R. E. Baker, Orleans.
2. Address of welcome—Mrs. George R. Dillinger, French Lick.
3. Greeting—E. E. Padgett, M. D., Indianapolis.
4. Business:
 Report of Secretary:
 Mrs. R. L. Compton, Osgood.
 Report of Treasurer:
 Mrs. U. G. Poland, Muncie.
 Report of Corresponding Secretary:
 Mrs. C. N. Combs, Terre Haute.
 Reports of Standing Committees:
 Historian, Mrs. J. T. Wheeler, Indianapolis.
 Public Relations, Mrs. Ed Clark, Indianapolis.

Hygeia, Mrs. J. H. Hare, Evansville.
Legislation, Mrs. E. E. Padgett, Indianapolis.
Organization, Mrs. J. H. Weinstein, Terre Haute.

5. Reports of Auxiliary Presidents: Mrs. C. M. Mix, Delaware-Blackford County.
Mrs. William S. Tomlin, Marion County.
Mrs. C. E. Ragan, Vigo County.
Mrs. Lowell G. Hunter, Ripley County.
Mrs. Marcus Ravdin, Vanderburgh County.
Mrs. George B. Metcalf, Madison County.
Mrs. George R. Dillinger, Orange County.
Mrs. Perry Woolery, Lawrence County.
6. Report on Milwaukee convention: Mrs. R. L. Compton, Osgood.
7. Address—J. H. Weinstein, M. D., Terre Haute.
8. Report of Nominating Committee.
9. Election of officers.

10:30 a. m. Inspection of the Pluto Bottling Plant at French Lick Springs Hotel. Ladies will assemble on Hotel porch.

12:00 m. Luncheon for all women going to Spring Mill State Park, main dining room, French Lick Springs Hotel.

1:30 p. m. Automobile trip to Spring Mill State Park. Assemble at front entrance of French Lick Springs Hotel.

2:30 p. m. "History of Spring Mill Village," by Mr. E. Y. Guernsey.



3 to 4 p. m. Tea at the Tavern, Spring Mill State Park. Lawrence County Auxiliary presiding.

9:00 p. m. Theater party, main convention hall, French Lick Springs Hotel.

10:30 p. m. Informal dance in Hotel lobby. Cards and general get-together, mezzanine floor.

Wednesday, September 27, 1933

10:30 a. m. Program, Kathryn Turney Garten, "Fall Publications," French Lick Springs Golf Club. Assemble at main entrance of Hotel for cars to the Golf Club.

12:30 p. m. Luncheon bridge, French Lick Springs Golf Club.

7:00 p. m. Annual banquet, main dining room, French Lick Springs Hotel. Principal speakers, Walter L. Bierring, M. D., Des Moines, Iowa, president-elect, American Medical Association; and Morris Fishbein, M. D., Chicago, editor of *The Journal of the American Medical Association.*
Dancing in main lobby of hotel until midnight.

OFFICIAL PROGRAM OF THE ANNUAL SESSION OF THE INDIANA STATE MEDICAL ASSOCIATION

TO BE HELD AT THE
FRENCH LICK SPRINGS HOTEL
SEPTEMBER 25, 26, 27, 1933

(Schedule will be carried out on central standard time.)

House of Delegates

First meeting, convention hall, convention building, Monday, September 25, at 4:00 p. m.

Second meeting, west dining room, Wednesday, September 27, at 7:00 a. m. (Breakfast meeting.)

Council

First meeting, special dining room, Monday, September 25, at 12:30 p. m. (Luncheon meeting.)

Second meeting, Wednesday, September 27, immediately upon adjournment of House of Delegates breakfast meeting.

Additional meetings at the call of the Chairman of the Council.

General Scientific Meetings

First meeting, Tuesday, September 26, convention hall, convention building, from 2:00 p. m. to 5:30 p. m.

Second meeting, Wednesday, September 27, main convention hall, convention building, from 2:00 p. m. to 5:00 p. m.

Section Meetings

First meeting, instructional courses, Tuesday, September 26, convention building, from 9:00 a. m. to 12 noon. These courses deal with problems faced by men doing general practice.

Second meeting, regular section meetings, Wednesday, September 26, convention building, from 9:00 a. m. to 12 noon.

Medical Economic Meeting

Economic round table discussion, Tuesday, September 26, west dining room, 12:15 p. m. to 2:00 p. m. Governor Paul V. McNutt, guest of honor.

Meeting of Women Physicians

Dinner meeting, Tuesday, September 26, French Lick Springs Hotel, at 6:30 p. m. Speaker: Alice Pickett, M. D., Louisville, Ky.

Meeting of Woman's Auxiliary

Breakfast and annual business meeting, Tuesday, September 26, west dining room, at 8:30 a. m.

Scientific Exhibits

All day Monday, Tuesday and Wednesday, in the exhibit hall, convention building.

Commercial Exhibits

All day Monday, Tuesday and Wednesday, in exhibit hall, convention building.

Registration

All day Monday, Tuesday and Wednesday, at the registration desk, exhibit hall, convention building.

Entertainment

Monday, September 25:

Annual golf tournament, French Lick Springs Country Club, 9:00 a. m. to 5:00 p. m., with golfers' luncheon served at the French Lick Springs Hotel at 12:15 p. m. (No greens fees to hotel guests. Golfers, however, pay own caddie fees.)

For those golfers registered at the French Lick Springs Hotel there will be no greens fees; for those not registered at the Hotel the fee will be one dollar.

Golf for women, 9:00 a. m. (Women wishing to play golf at any time during the convention will please procure free tickets at the convention registration desk.)

Trap shoot for men, Dry Hollow, French Lick Springs Hotel, at 1:30 p. m.

Mystery Field Day with events for women as well as men, 3:00 p. m., east of eighteenth green, Hotel golf course.

Annual smoker, stag dinner and get-together, basement of convention building, French Lick Springs Hotel, 7:00 p. m. Novel entertainment and awarding of golf prizes.

Dinner party and entertainment for wives and families of physicians, 7:00 p. m., west dining room, French Lick Springs Hotel, followed by informal reception, mezzanine floor.

Tuesday, September 26:

Annual breakfast of the Woman's Auxiliary to the Indiana State Medical Association at 8:30 a. m., west dining room, French Lick Springs Hotel.

Trip through Pluto Bottling Plant, French Lick Springs Hotel, at 10:30 a. m. Assemble on Hotel porch.

Luncheon for women going to Spring Mill State Park, main dining room, French Lick Springs Hotel at 12 noon.

Automobile trip to Spring Mill State Park (about 6 miles east of Mitchell, Ind., Lawrence County). Historical talk and tea at State Park Tavern, 1:30 to 4:00 p. m. Assemble at front entrance of hotel.

Fraternity, class and ex-service men's dinners, get-togethers and banquets, various dining rooms, French Lick Springs Hotel, at 6:30 p. m. (Talks by M. F. Daubenheyer, M. D., formerly in government service, upon "State Medicine," and F. S. Crockett, M. D., past president, on "Veterans' Hospitalization," at ex-service men's dinner.)

Dinner for women physicians at 6:30 p. m. Speaker: Alice Pickett, M. D., Assistant Professor of Obstetrics, University of Louisville School of Medicine.

Theater party for physicians, their wives and guests, main convention hall, convention building, at 9:00 p. m.

Informal dance in Hotel lobby, cards and general get-together, mezzanine floor, 10:30 p. m.

Wednesday, September 27:

Program for women, French Lick Springs Golf Club, at 10:30 a. m. Women will assemble at main entrance of hotel for cars to the Golf Club.

Luncheon bridge for women, French Lick Springs Golf Club, at 12:30 p. m. (Luncheon, compliments of the French Lick Springs Hotel.)

Annual banquet for physicians, wives and guests, main dining room, French Lick Springs Hotel. Principal speakers and guests of honor: Walter L. Bierring, M. D., Des Moines, Iowa, president-elect, American Medical Association; and Morris Fishbein, M. D., Chicago, editor of *The Journal of the American Medical Association.* (No charge for banquet or special meals *for anyone registered at the French Lick Springs Hotel.*)

SCIENTIFIC PROGRAM

(Schedule will be carried out on central standard time.)

Tuesday, September 26, 1933

MORNING

9:00 to 12:00 m.	*Instructional Courses.* The morning is to be divided into instructional courses conducted by each of the the three sections with the chairman of each section presiding. These courses deal with problems faced by the man doing general practice.

MEDICAL SECTION

(Main Convention Hall)

R. L. Sensenich, M. D., South Bend, Chairman, Medical Section, Presiding

"HEAD"

9:00 to 9:50 a. m. Bernard D. Ravdin, M. D., Evansville.
9:50 to 10:00 a. m. Discussion.

"CHEST"

10:00 to 10:50 a. m. Robert M. Moore, M. D., Indianapolis.
10:50 to 11:00 a. m. Discussion.

"ABDOMEN"

11:00 to 11:50 a. m. George F. Green, M. D., South Bend.
11:50 to 12:00 m. Discussion.
(Arranged by Dr. Herman Baker, Evansville.)

SURGICAL SECTION

(North Room)

E. Vernon Hahn, M. D., Indianapolis, Chairman, Surgical Section, Presiding

"FRACTURES"

9:00 to 9:50 a. m. A. V. Cole, M. D., Indiana Harbor.
9:50 to 10:00 a. m. Discussion.

"GASTRO-INTESTINAL TRACT"

10:00 to 10:50 a. m. Rollin H. Moser, M. D., Indianapolis.
10:50 to 11:00 a. m. Discussion.

"RECTAL CONDITIONS—PRACTICAL VIEWPOINT"

11:00 to 11:50 a. m. Bruce H. Beeler, M. D., Evansville.
11:50 to 12:00 m. Discussion.
(Arranged by Dr. H. O. Mertz, Indianapolis.)

SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY

(Basement of Convention Hall)

W. S. Tomlin, M. D., Indianapolis, Chairman, Section on Ophthalmology and Otolaryngology, Presiding

"EYE REFLEXES AS THEY AFFECT THE MAN IN GENERAL PRACTICE"

9:00 to 9:50 a. m. George S. Row, M. D., Indianapolis.
9:50 to 10:00 a. m. Discussion.

"OTITIS MEDIA"

10:00 to 10:50 a. m. Hugh A. Kuhn, M. D., Hammond.
10:50 to 11:00 a. m. Discussion.

"SINUSITIS"

11:00 to 11:50 a. m. C. Norman Howard, M. D., Warsaw.
11:50 to 12:00 m. Discussion.
(Arranged by Dr. S. T. Miller, Elkhart.)

Tuesday, September 26, 1933

AFTERNOON

12:15 to 2:00 p. m. Economic round table discussion, E. E. Padgett, M. D., Indianapolis, president-elect, leading. Luncheon meeting, west dining room, French Lick Springs Hotel.



GOVERNOR PAUL V. MCNUTT
Guest of Honor

PROGRAM

1. Walter F. Kelly, M. D., Indianapolis.
 State committee for Investigation of Various Insurance Schemes.
2. W. D. Gatch, M. D., Indianapolis.
 Indiana University Medical School and the Doctor in Practice.
3. Paul Johnson, M. D., Richmond.
 The County General Hospital in Relation to Group Hospitalization.
4. A. W. Cavins, M. D., Terre Haute.
 Report of Survey of Various Counties as to Care of the Indigent.
5. Paul Garber, M. D., Whiting.
 Lay Journal for the Exposure of Quackery.
6. A. M. Mitchell, M. D., Terre Haute.
 How Members Can Co-operate with County Secretaries.

Discussion led by O. O. Alexander of Terre Haute, Chairman of the Council.

2:00 p. m. General scientific meeting, convention hall. Call to order by J. H. Weinstein, M. D., Terre Haute, president, Indiana State Medical Association.

2:00 p. m. Greetings from George R. Dillinger, M. D., chairman of Committee on Arrangements.

2:05 p. m. Greetings from H. C. Ragsdale, M. D., councilor of Third District.

2:10 p. m. Informal welcome talk by Tom Taggart.

2:15 to 2:45 p. m. President's address, Joseph H. Weinstein, M. D., Terre Haute.

Scientific Program

2:45 to 3:05 p. m. JOHN H. WARVEL, M. D., Indianapolis.
Subject: "Management of Diabetes."

Abstract:—Many radical changes in the dietetic treatment of diabetes in the last thirty years. The advent of Insulin, and the more hopeful outlook for the diabetic patient. The attitude of the physician in regard to Insulin at the present time. Incidence and mortality rates in diabetes during the past ten years. Salient features in diagnosis. Some common dietetic fallacies. Presentation of simplified diets for diabetic patients. Methods of determination of Insulin dosage. The prevention and treatment of complications. The modern treatment of coma. Surgery and the management of the diabetic patient. Presentation of the common causes for failure of treatment. The value of oral preparations. Regulation of hygiene for diabetes. The health status of present day diabetic. Constant instruetion and encouragement on the part of the physieian is essential at all times.

3:05 to 3:15 p. m. Discussion: Gayle J. Hunt, M. D., Richmond.

3:15 to 3:35 p. m. ALOIS L. ZILIAK, M. D., Princeton.
Subject: "Cancer: Etiological Conditions."
(Abstract not received.)

3:35 to 3:45 p. m. Discussion: Virgil McCarty, M. D., Princeton.

3:45 to 4:00 p. m. Intermission.

4:00 to 4:20 p. m. HOWARD C. BALLENGER, M. D., Chicago.
Subject: "Otolaryngology in General Practice."



H. C. BALLENGER

Abstract:—Upper respiratory tract infections and their eomplieations constitute the majority of all cases of otolaryngology seen by the general physician. The relationship of head colds and influenza is discussed and also the complications of upper respiratory tract infeetions. Hemolytic streptocoecic throat infections are stressed, with the importance of the blood stream method of transmission emphasized. The best treatment of these conditions is in the ineipieney of the nose and throat infection. An outline of a simple treatment of head eolds and congested throats is given.

4:20 to 4:40 p. m. CARL P. SCHOEN, M. D., New Albany.
Subject: "Post Operative Atelectasis."

Abstract:—Importance of correct diagnosis and frequency of error in diagnosing this eondition. Review of reported cases. Etiology of atelectasis. Pathology of postoperative atelectasis. Incidence and symptoms. Treatment.



V. K. HARVEY

4:40 to 5:00 p. m. VERNE K. HARVEY, M. D., Indianapolis, director, Indiana State Division of Public Health.
Subject: "The Medical Profession and the Reorganization of the State Board of Health."

5:00 to 5:30 p. m. General discussion.

Wednesday, September 27, 1933

MORNING

Section Meetings

MEDICAL SECTION

Chairman, R. L. Sensenich, South Bend
Vice-Chairman, W. F. Carver, Albion
Secretary, C. J. Clark, Indianapolis
(Main Convention Hall)

9:00 a. m. BAYARD G. KEENEY, M. D., Shelbyville.
Subject: "The Determinants of Kidney Function."

Abstract:—Discussion of water metabolism, water retention and diuresis; priority claim of tissues for water; the level of blood metabolites an index of tissue metabolism, not renal impairment. Albuminuria; oedema; uremia-therapy.

Discussion: E. O. Harrold, M. D., Marion.

9:35 a. m. CECIL LOGAN RUDESILL, M. D., Indianapolis.
Subject: "Differential Diagnosis of Biliary Diseases."

Abstract:—The diseussion will deal with the most common acute infections, eholelithiasis, and malignancy affecting the liver, bile ducts, and gall bladder. Emphasis will center upon various elinical and laboratory observations that may aid in a differential diagnosis of these conditions. Clinical interpretation of tests will be considered rather than detailed technique.

Discussion: G. M. Cook, M. D., Hammond.

10:10 a. m. JOHN ERIC DALTON, M. D., Indianapolis.
Subject: "Lymphogranulomatosis Inguinalis."

Abstract:—A specifie, subaeute, indolent, inguinal adenitis of venereal origin, sometimes oecurring in other than inguinal regions, which, due to similarity of nomenelature, has been confused with granuloma inguinale, although it will be shown here to be a definite entity, through (1) clinieal manifestations, (2) pathological studies, and (3) positive Frei reaction. Although long recognized, in other eountries and sections of the United States, here are reported the first eases to be studied in Indiana. During the past one and one-half years, vigilant watch has been held for these patients at the University and City Hospital Clinics in Indianapolis, which resulted in some twenty sueh cases being found. Report of these are made with a discussion of occurrence, incubation, etiology, bacteriologieal

and histopathological studies, clinical symptoms, Frei diagnostic test, prognosis and therapy.

Discussion: A. S. Giordano, M. D. South Bend.

10:45 a. m. Election of section officers.

10:55 a. m. RUSSELL ALLEN FLACK, M. D., Lafayette.
Subject: "Coronary Occlusion."

Abstract:—Several case histories briefly reviewed. The etiological factors leading up to coronary occlusion are enumerated. The pathological changes demonstrable at autopsy are discussed. The clinical signs and symptoms are classified as to mechanism of production. The prognosis during and subsequent to an acute attack is discussed. The importance of the prompt institution of the proper treatment during the acute attack, and prolonged intensive care subsequent to the acute attack is emphasized.

Discussion: F. E. Sayers, M. D., Terre Haute.

11:30 a. m. PIERCE MACKENZIE, M. D., Evansville.
Subject: "Diet and Fluids in Pregnancy."

Abstract:—The importance of food and drink during pregnancy is considered in relation to the early and late toxaemias of pregnancy, the prevention of anaemia, elimination by the bowels and kidneys, the importance of the weight-gain of the mother, and the importance of the maternal diet to the child to be born.

Discussion: K. M. Beierlein, M. D., Ft. Wayne.

11:30 a. m. Election of section officers.

SURGICAL SECTION

Chairman, E. Vernon Hahn, Indianapolis
Vice-Chairman, H. C. Ragsdale, Bedford
Secretary, J. R. Pugh, Hammond

(North Room, Convention Building)

9:00 a. m. JAMES Y. WELBORN, M. D., Evansville.
Subject: "Treatment of Fractures."

Abstract:—Increase in bone trauma in recent years. Importance of first treatment. Pitfalls in fracture work. Consideration of fractures of the skull, spine, elbow, femur, tibia, fibula, and of Colles' fracture.

9:30 a. m. Discussion: E. V. Wiseman, M. D., Greencastle.

9:35 a. m. FRANK H. JETT, M. D., Terre Haute.
Subject: "Aseptic Treatment of Primary Wounds."

Abstract:—The faith of the general medical profession in the chemical sterilization of wounds has not been justified by modern experiment or experience. It is fundamental that it is better to remove bacteria and foreign material than attempt to sterilize. The conclusion is drawn that wounds can only be properly cleansed when anesthetized. Local anesthesia is shown to be a simple thing rather than a complicated technique, which is usually described in textbooks, and is very effective, also that general anesthesia is imperative for the proper care of any large wound. A method is suggested to limit the amount of skin grafting in a simple way.

10:05 a. m. Discussion: Joseph H. Clevenger, M. D., Muncie.

10:10 a. m. M. C. SEXTON, M. D., Rushville.
Subject: "Experience with Spinal Anesthesia."
(Abstract not received.)

10:40 a. m. Discussion: Frank B. Ramsey, M. D., Indianapolis.

10:45 a. m. N. K. FORSTER, M. D., Hammond.
Subject: "Consideration in the Management of Functional Disturbances of Menstruation."

Abstract:—The present conception of the factors concerned in normal menstruation is reviewed. Those irregularities of the cycle, based upon functional disorders only, are considered at different ages, and their management discussed.

11:15 a. m. Discussion: Leo K. Ryan, M. D., Gary.

11:20 a. m. General discussion.

12:00 m. Election of section officers.

SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY

Chairman, W. S. Tomlin, Indianapolis
Vice-Chairman, Hugh A. Kuhn, Hammond
Secretary, F. V. Overman, Indianapolis

(Basement of Convention Building)

9:00 a. m. Chairman's address, W. S. Tomlin, M. D., Indianapolis.

9:10 a. m. Election of section officers.

9:30 a. m. RAYMOND C. BEELER, M. D., and JAMES N. COLLINS, M. D., Indianapolis.
Subject: "The Diagnosis of Maxillary Sinusitis by the Use of Opaque Oils."

Abstract:—Many roentgenographic diagnoses were questioned before the use of opaque media. With the filling defects shown by the injected maxillary sinus, there are fewer mistakes. It is not necessary to use elaborate technics or positions to show the pathology present. The customary sinus films are always preferred before the oil injection. Some of the possible errors are discussed. Cases are shown to illustrate the mistakes that might have been made from the primary films.

Discussion: W. E. Stewart, M. D., Terre Haute.

10:15 a. m. EUGENE L. BULSON, M. D., Ft. Wayne.
Subject: "Malignant Disease of the Larynx; Peroral Endoscopy as an Indispensable Aid in Its Early Diagnosis."

Abstract:—The importance of chronic hoarseness as a symptom of early malignancy is emphasized in persons of middle life. Early intrinsic laryngeal cancers occur most frequently in the anterior two-thirds of the larnyx. All patients with intractable hoarseness should be given the benefit of careful examination by a competent observer. The classification of carcinomas is given, showing the relative frequency of the various types. The symptoms and diagnosis with special reference to tuberculosis and syphilis is discussed. Biopsy should be made as a last resort and is often necessary for a positive diagnosis. The easiest and best method of performing this is by means of direct laryngoscopy; a thorough examination of the interior of the larynx can be made by no other means. The question of the dangers of biopsy is discussed and statistics quoted. In the treatment, laryngofissure is the operation of choice for early intrinsic malignant tumors, involving the anterior portion of the larynx, while laryngectomy is done for the more extensive lesions. Radium and x-ray are used more as palliative measures. Reports of cases, one with intrinsic cancer of the larynx and one with extrinsic cancer.

Discussion: J. Vernal Cassady, M. D., South Bend.

10:50 a. m. JAMES C. CARTER, M. D., Indianapolis.
Subject: "The Pediatrician and the Otolaryngologist."

Abstract:—Infection and immunity; otitis media; tonsillitis; sinus infection; tonsils and adenoids; common colds; allergy.

Discussion: A. F. Clements, M. D., Evansville.

11:25 a. m. E. W. DYAR, M. D., Indianapolis.
Subject: "The Value of Perimetry in Ocular Diagnosis and Prognosis."

Abstract:—The perimeter is one of the finest instruments of precision in determining the condition and extent of pathology in the entire visual pathway. The various instruments, their modifications, and technique of the examination. A review of eighty unselected cases, with lantern slide demonstration of the more typical and instructive cases, especially glaucoma and sinus disease. The perimeter is an indispensable part of the oculist's equipment.

Discussion: W. O. McBride, M. D., Ft. Wayne.

Wednesday, September 27, 1933

AFTERNOON

General scientific meeting, main convention hall, convention building. General instructional program of interest to the man in general practice.



A. H. CURTIS

2:00 to 2:45 p. m.

ARTHUR HALE CURTIS, M. D., Professor of Obstetrics and Gynecology, Northwestern University Medical School, Chicago.
Subject: (Not given.)



L. J. HIRSCHMAN

3:00 to 3:45 p. m.

LOUIS JACOB HIRSCHMAN, M. D., Vice-President, American Medical Association; Professor of Proctology, Detroit College of Medicine and Surgery, Detroit.
Subject: "The Proctologist Looks at Focal Infection."

Abstract:—In the search for and detection of foci of infection to account for many distressing symptoms, most of our efforts have been limited to the areas connected with the mouth, throat and upper air passages. The most frequently overlooked and certainly a most fertile focus is the colon. Its terminal portion, the anal canal, is of especial interest in this connection. Many patients have been relieved and restored to health after proper surgical and vaccine therapy, instituted after study of pathology disclosed after thorough examination of the anal canal, rectum, and colon. Technic of examination and treatment described.



ERNEST SACHS

4:00 to 4:45 p. m.

ERNEST SACHS, M. D., Clinical Professor of Neurological Surgery, Washington University School of Medicine, St. Louis.
Subject: "Brain Tumors; Why the Diagnosis Is Better and the Operative Results More Satisfactory."

Abstract:—The improvements in early diagnosis. Description of symptoms that formerly were not recognized as of localizing value. Changes in technical methods in the past five years and the addition of ventriculography.

(Ten minutes to be given for questions or queries following each presentation.)

Wednesday, September 27, 1933

EVENING

ANNUAL BANQUET

7:00 p. m. Main dining room, French Lick Springs Hotel.
Presiding officer, Joseph H. Weinstein, M. D., presiding, Indiana State Medical Association.



WALTER L. BIERRING



MORRIS FISHBEIN

Presentation of certificate of merit to F. S. Crockett, president of Indiana State Medical Association, 1932, by J. H. Weinstein, president, 1933.

Speakers

WALTER L. BIERRING, M. D., Des Moines, Iowa, president-elect, American Medical Association.

Subject: "The Function of the American Medical Association in Medical Education."

MORRIS FISHBEIN, M. D., Chicago, editor of *The Journal of the American Medical Association.*

Subject: "Present Trends in Medical Practice."

COMMITTEES FOR 1933 SESSION INDIANA STATE MEDICAL ASSOCIATION

General Arrangements

George Dillinger, French Lick, general chairman
C. E. Boyd, West Baden
H. C. Ragsdale, Bedford
P. H. Schoen, New Albany
H. H. Reeder, Jeffersonville

Finance

Mart Hassenmiller, West Baden, chairman
Robert Harris, New Albany
Charles H. Emery, Bedford

Lanterns

W. E. Schoolfield, Orleans, chairman
Paul T. Lamey, Bedford
Carl Schoen, New Albany

Hotels

H. L. Miller, West Baden, chairman
O. E. Stewart, Orleans
S. F. Teaford, Paoli

Publicity

S. L. Lingle, Paoli, chairman
Dudley F. Davis, New Albany
Marvin McClain, Scottsburg
H. C. Knapp, Huntingburg
Howard Allen, Bedford

Banquet

R. E. Baker, Orleans, chairman
J. H. Baldwin, Jeffersonville
John P. Gentile, New Albany
Claude Dollens, Oolitic

Registration

W. H. Patton, Orleans, chairman
J. C. Dusard, Bedford
Parvin M. Davis, New Albany
I. B. Huckleberry, Salem
N. E. Gobble, English

Golf

H. B. Shacklett, New Albany, chairman
A. P. Hauss, New Albany
A. E. Newland, Bedford
C. E. Stouder, Bedford
W. A. Hall, New Albany

Entertainment

G. G. Colglazier, Leipsic, chairman
W. W. Hoggatt, French Lick
C. E. Stone, Bedford

Automobile

C. E. Boyd, West Baden, chairman
R. L. Holiday, Paoli
W. H. Patton, Orleans
W. H. McKnight, Bedford

Fraternities

Robert Smallwood, Bedford, chairman
Marvin McClain, Scottsburg
F. M. Applegate, Corydon
A. N. Robertson, Salem

Trap Shoot

J. I. Maris, Paoli, chairman
J. R. Dillinger, French Lick
Walter Sherwood, Mitchell
N. R. Byers, Bedford
J. E. Bird, New Albany

Meeting of Women Physicians

Anna McKamy, New Albany, chairman

Military Service

J. R. Dillinger, French Lick, chairman
W. E. Amy, Corydon
George H. Day, New Albany
A. E. Newland, Bedford

Reception

H. C. Ragsdale, Bedford, chairman
C. E. Boyd, West Baden
W. S. Workman, Orleans
St. John Lukemeyer, Jasper
Leo E. Salb, Jasper
R. E. Wynne, Bedford
L. H. Allen, Bedford
G. B. Hammond, English
Claude B. Paynter, Salem
Frank A. May, Palmyra
William E. Amy, Corydon
J. P. Wilson, Scottsburg
Giles E. Mowrer, Jeffersonville
Wm. Windstandley, New Albany
Amzie Weaver, New Albany

Women's Entertainment

Mrs. George Dillinger, French Lick
Mrs. C. E. Boyd, West Baden
Mrs. R. E. Baker, Orleans
Mrs. H. L. Miller, West Baden
Mrs. W. W. Hoggatt, French Lick
Mrs. J. R. Dillinger, French Lick
Mrs. S. F. Teaford, Paoli
Mrs. R. L. Holiday, Paoli
Mrs. G. G. Colglazier, Leipsic

SCIENTIFIC EXHIBIT

Ernest Rupel, M. D., Indianapolis, Director of Scientific Exhibit
Clyde G. Culbertson, M. D., Indianapolis, Assistant Director

I. PROFESSOR R. N. HARGER, Indiana University School of Medicine.
"Scientific Aids to Forensic Medicine; demonstrating detection of poisons, bloodstains, seminal stains, hair, drunkenness, age of handwriting, etc."

II. INDIANA STATE DIVISION OF PUBLIC HEALTH, Verne K. Harvey, M. D., director.

COMMITTEE REPORTS

REPORT OF COMMITTEE ON CREDENTIALS

House of Delegates, Indiana State Medical Association:

Gentlemen: We have made a sweeping investigation as to making a change in the seating of our delegates and have found no better plan than the one followed by our Association for the past several years, and we, the Committee, recommend that every delegate come to our meeting at French Lick with the proper credentials or send them to our executive secretary before the day of meeting.

Respectfully submitted,

GEORGE D. MILLER, M. D., Chairman.
J. W. SMADEL, M. D.
P. H. SCHOEN, M. D.

REPORT OF THE EXECUTIVE SECRETARY

House of Delegates, Indiana State Medical Association:

Gentlemen: The annual reports of the various committees show, better than anything that your secretary might write, the progress that is being made by the Indiana State Medical Association. A medical society exists primarily for scientific purposes, but with the change in social and economic conditions, the profession has found that if it is to maintain its high scientific standards and remain true to its inherited traditions it must interest itself with many matters that are essentially social and economic and not scientific in nature.

To what extent this is true in Indiana may be gathered from even the most casual perusal of the annual reports of the officers, councilors, and the twenty-six special and standing committees of the Association which have been prepared for the House of Delegates. Of course it is too much to expect that every word of every report will be read by every physician or even, for that matter, by every delegate, but the officers of the Association do hope that each doctor will find time to check over each report and at least be familiar with the major points and know what matters are of special

concern to the profession at this time. These reports are not merely phrases written by paper committees—they detail almost without exception a survey of the work undertaken, things actually accomplished, and recommendations proposed for future activities. They represent countless hours of untiring and unremunerative effort given in the interest of the medical profession by numerous individual members who are doing their bit to maintain the leadership of organized medicine in those matters that have to do with the health and welfare of the public.

Here are some of the major issues that have been dealt with successfully by the Indiana profession during the past twelve months:

I. *National Economy Act:* Every Indiana physician may point with pride to the major part that the representatives of the Indiana State Medical Association played in laying the ground work for the National Economy Act which finally resulted in the elimination of government medical attention to ex-service men sustaining non-service-connected disabilities. The spokesman of the State Association presented the viewpoint of the medical profession before the Shannon Committee at its hearing held in South Bend, and it was as a result of this testimony as well as that of the American Medical Association that the committee made its recommendation for elimination of payments for non-service-connected disabilities.

II. *Group Hospitalization:* Since inception of group hospital insurance plans, early this year, the officers of the Indiana State Medical Association have warned the profession not to enter into such schemes without first making a very careful investigation. Many high-pressure salesmen have besieged Indiana, urging various hospitals to set up such plans. An article giving the viewpoint of the old-line insurance companies in regard to this question appeared in the August number of THE JOURNAL. The Indiana JOURNAL, so far as we know, was the first one to obtain and publish the views of the large insurance companies upon these questions. While many other localities have been over-ridden with this practice, so far as is known no reputable Indiana hospital has yet undertaken such schemes, none of which have been approved by the American Medical Association.

IV. *R. F. C. Funds for Care of the Indigent:* Indiana, we believe, is the first state to make R. F. C. funds available for treatment of the indigent sick. This plan was worked out with the State Relief Commission and probably will serve as a basis for such arrangements in other states.

V. *Contract Practice:* Contract practice has grown to such proportions and become such a factor in some states that it has disrupted county societies and has undermined the medical profession to such a point that competition in some communities has brought service values down to the vanishing point.

VI. *Economic Lectures:* A lecture course on medical economics and medical ethics has been instituted in Indiana University as the result of the action of the House of Delegates of the Indiana State Medical Association last year. The Indiana resolution was adopted by the House of Delegates of the American Medical Association in June and the recommendations passed on to other universities of the country.

VII. THE JOURNAL: Publication of the JOURNAL of the Indiana State Medical Association was undertaken from the headquarters office starting last January.

VIII. *Cultists:* The cultists, despite desperate efforts, once more were unable during the past year to pass legislation which would give them preference over the medical profession. Their bills were defeated and, although they made advances in several other states, they were checked in their tracks in Indiana.

IX. *Membership:* Despite decreases in membership that have reached as high as fifty per cent of normal in some state societies, the Indiana State Medical Association is off less than five per cent in its membership, a remarkable record considering the depression period through which we have just passed.

These are only a few of the high points of the year, details in regard to which may be found in the annual reports that follow and in the articles appearing in THE JOURNAL from month to month. By bulletins, letters, trips to every district and almost every county medical society of the state, the profession has been kept aware of the new movements and new ideas that are coming at breath-taking speed and for which the medical profession must have satisfactory solutions.

Respectfully submitted,

THOMAS A. HENDRICKS,
Executive Secretary.

REPORT OF THE TREASURER

House of Delegates, Indiana State Medical Association:

Gentlemen: In making this year's report, several features have entered since our last accounting which show the effects of the recent economic situation. Naturally, we expected some loss in revenue due to a falling off in membership. This has happened, as shown by the comparative figures of last year and this year. While the loss is not great, it calls to our attention the necessity of bringing in every possible eligible member.

I should like to leave for your consideration some suggestions. Since it is practically impossible to make an audit of THE JOURNAL before December 31, 1933, at which time THE JOURNAL will have been in operation one full year under the supervision of the Council, we shall have to ask you to wait until the end of the year for an adequate accounting. Most of THE JOURNAL contracts are

made on a yearly basis; therefore, it is evident that any summary will have to be made at the end of that period. Since THE JOURNAL and the Association headquarters are now combined, it seems that a more satisfactory audit can be made if both THE JOURNAL and the Association closed their books at the same time, namely, December 31st. Should you think that this is the proper thing to do, it will necessitate another audit of the Association books on December 31, 1933, but no other audit until December 31, 1934.

Because of the national bank moratorium in March, 1933, checks for dues from fifteen members, totalling $105, were received but not honored at the banks on which they were written. However, $42 of this amount was collected in the month of August and it is likely that the remainder will be collected before the end of the year.

Another item of revenue which had not been received on July 31, 1933, is that for exhibit rentals, totalling $442.50, which will be received before the annual session in September. These two items of revenue, totalling $557.50, will more than offset any loss shown at July 31, 1933.

Indianapolis, Indiana,
August 9, 1933.

Indiana State Medical Association,
Indianapolis, Indiana.

Gentlemen: Per your request I have examined and audited the accounts of your association for the fiscal year ended July 31, 1933, and a report of same is rendered herewith:

Page 1 Exhibit "A," Statement of Application of Funds.

Page 2, Exhibit "B," Comparative Statement of Application of Funds.

Page 3, Exhibit "C," Comparative Statement of Surplus Account.

Page 4, Exhibit "D," Report of Petty Cash Fund.

Page 5, Exhibit "E," Reconciliation of Bank Account.

No interest has been received during the last two years from the Rokeby Apartment Hotel Bond nor the Beachton Court Apartments Bonds. These bonds are in the custody of the Phillip State Bank and Trust Company and are supported by certificates of deposit on file in the Executive Secretary's office.

The following bonds are in a safety box at the Meyer-Kiser Bank:

6 City Hospital$1,000.00 each
5 Flood Prevention ... 1,000.00 each
2 Lake County Highway 1,000.00 each
5 School City 1,000.00 each

The five Liberty Bonds and one City Hospital Bond are filed in a separate compartment in the safety deposit box, and are for the purpose of supporting a $6,000.00 Medical Defense Fund as prescribed by the by-laws of the association.

No examination was made of the accounts of THE JOURNAL of the Indiana State Medical Association; however, we suggest they be examined as of December 31, 1933.

Respectfully submitted,
R. E. WELCH, Auditor.

Statement of Application of Funds
August 1, 1932, to July 31, 1933

INCOME:		
Membership dues	$16,069.25	
Medical defense reserve	1,928.75	
Interest on checking account	63.51	
Interest on liberty bonds	212.45	
Interest on flood prevention bonds	212.50	
Interest on school improvement bonds	224.70	
Interest on city hospital bonds	247.50	
Interest on state highway bonds	149.60	
Postgraduate study	86.00	
Income from exhibits	1,015.00	
Total Income		$20,209.26
EXPENDITURES:		
Executive office	$9,219.82	
Publicity committee	361.55	
Public policy	405.94	
JOURNAL	5,160.00	
Council	268.16	
Treasurer's office	161.30	
Annual session	1,831.07	
Miscellaneous committees	344.69	
Attorney fees	600.00	
Medical defense	1,828.00	
Postgraduate committee	192.32	
Total Expenditures		$20,372.85
Net Loss		163.59
Plus Balance August 1, 1932		7,281.40
Balance July 31, 1933		$7,117.81

EXHIBIT "A"

Comparative Statement of Application of Funds
August 1, to July 31, 1932, and 1933

	1932	1933	Increase	Decrease
INCOME:				
Membership dues	$16,981.05	$16,069.25		$911.80
Medical defense reserve	2,037.95	1,928.75		109.20
Interest on checking account	135.50	63.51		71.99
Interest on liberty bonds	212.50	212.45		.05
Interest on flood prevention bonds.	318.75	212.50		106.25
Interest on school improvement bonds	225.00	224.70		.30
Interest on city hospital bonds	247.50	247.50		
Interest on state highway bond		149.60	149.60	
Income from exhiits	2,210.00	1,015.00		1,195.00
T. A. Hendricks, unused expense	16.26			16.26
Postgraduate study.	427.50	86.00		341.50
Indiana State Dental Association	8.00			8.00
Total income	$22,820.01	$20,209.26	$149.60	$2,760.35

EXPENDITURES:				
Executive office	$11,223.19	$9,219.82		$2,003.37
Publicity committee	389.90	361.55		28.35
Public policy	79.38	405.94	326.56	
JOURNAL	5,420.00	5,160.00		260.00
Council	188.57	268.16	79.59	
Treasurer's office	208.75	161.30		47.45
Annual session	2,371.89	1,831.07		540.82
Miscellaneous committees	368.88	344.69		24.19
Attorney fees	516.69	600.00	83.31	
Medical defense	1,980.65	1,828.00		152.65
Postgraduate committee	245.79	192.32		53.47
Total Expenditures	$22,993.69	$20,372.85	$489.46	$3,110.30
Net Loss	$173.68	$163.59		
Net Loss 1932				$173.68
Net Loss 1933				163.59
Net Decrease				$10.09
Net Decrease in Income				$2,610.75
Net Decrease Expenditures				2,620.84
Total				$10.09

EXHIBIT "B"

Comparative Statement of Surplus Account at July 31, for the Year 1932 and 1933

	1932	1933
Surplus August 1, 1931 and 1932	$35,655.08	$35,481.40
Net loss for the year	173.68	163.59
Surplus July 31, 1932, and 1933	$35,481.40	$35,317.81

Analysis of Surplus Account

	1932	1933
Liberty bonds	$5,000.00	$5,000.00
Realty bonds	5,000.00	5,000.00
State highway bonds	2,000.00	2,000.00
City hospital bonds	6,000.00	6,000.00
Flood prevention bonds	5,000.00	5,000.00
School improvement bonds	5,000.00	5,000.00
Checking account	7,281.40	7,117.81
Petty cash	200.00	200.00
Totals	$35,481.40	$35,317.81

EXHIBIT "C"

Report of Petty Cash Fund
July 31, 1933

RECEIPTS		
Balance August 1, 1932	$200.00	
Checks received from treasurer	1,280.65	
Total		$1,480.65
EXPENDITURES		
Executive office	$624.73	
Publicity committee	162.89	
Public policy	341.48	
Council	3.00	
Annual session	94.10	
Miscellaneous committees	31.70	
JOURNAL	22.75	
Total		1,280.65
Balance July 31, 1933		$200.00

EXHIBIT "D"

Reconciliation of Bank Account
July 31, 1933

Balance per bank statement July 31, 1933		$7,262.46
Less Outstanding Checks:		
No. 561 Albert Stump	$50.00	
No. 563 THE JOURNAL of ISMA	60.00	
No. 564 Thomas A. Hendricks (petty cash)	34.65	
		144.65
Balance per books July 31, 1933		$7,117.81

Respectfully submitted,

A. F. WEYERBACHER, M. D.,
Treasurer.

EXHIBIT "E"

REPORT OF THE CHAIRMAN OF THE COUNCIL

House of Delegates, Indiana State Medical Association:

Gentlemen:

As the October, 1932, and the January, 1933, numbers of THE JOURNAL carry in detail the minutes of the Council, only a brief outline of the principal acts of the Council during the past year are herewith given by the chairman.

First Meeting, Michigan City, September 27, 1932

The Council convened at a meeting at the Spaulding Hotel, roll call showing all thirteen councilors present, along with the president, president-elect, treasurer, members of the Executive Committee, and the executive secretary.

Arrangements for Publication of THE JOURNAL

At executive session the following five men were chosen to form the editorial board for THE JOURNAL:

Dr. Charles N. Combs, Terre Haute, one-year term.

Dr. Ernest Rupel, Indianapolis, two-year term.

Dr. Floyd T. Romberger, Lafayette, three-year term.

Dr. Thurman B. Rice, Indianapolis, four-year term.

Dr. Pierce MacKenzie, Evansville, five-year term.

The Council expressed its appreciation for the services rendered by Dr. Miles Porter, Sr., of Fort Wayne, who acted in an advisory capacity in editing THE JOURNAL from the time of Dr. Bulson's death in July until THE JOURNAL was taken over by the new editorial board, January 1, 1933.

Bids for the publication of THE JOURNAL were received and the Executive Committee was empowered to select a publisher and make a contract for one year. (Subsequently the Executive Committee made the award to the William B. Burford Printing Company of Indianapolis.)

A special committee made a report on the amendments to the Constitution and By-Laws in regard to the editor of THE JOURNAL. This report was

accepted by the Council and was presented to the House of Delegates.

The Council approved the action of the Executive Committee in discontinuing from THE JOURNAL the page of special societies. The discontinuance of this page was done at the suggestion of the Council.

Arrangements for the preparation of a memorial to Dr. Bulson to be published in the anniversary number of THE JOURNAL were completed.

Public Relations Committee

Recommendation that the Council suggest to the House of Delegates that a public relations committee that is to represent the State Association in matters in regard to the State Board of Health, the State Board of Medical Registration and Examination, the Indiana University School of Medicine, and the public, accepted.

Second Meeting, Michigan City, September 29, 1933

All thirteen councilors were present along with the ex-officio members at the second meeting.

New Headquarters Office

Report of the findings of the Executive Committee in regard to the enlargement of headquarters office to accommodate THE JOURNAL presented to the Council. The Council empowered the Executive Committee to make a selection of the space.

Veterans' Hospitalization

Dr. F. S. Crockett, who acted as a delegate from the American Medical Association to the American Legion convention at Portland, Oregon, made a report specially concerning veterans' hospitalization to the Council.

Conflicts in District Meetings

The executive secretary again brought to the attention of the Council the fact that there still are conflicts in district meetings. His suggestion that a list of district meetings and the district officers, similar to the county secretaries' directory, be carried in THE JOURNAL, approved by the Council.

Correct Roster of Members

Dr. Kennedy, councilor of the Sixth District, reported upon the method he used to get the correct roster of members for each of the county societies in his district.

Apprcciation to Dr. J. B. Rogers, Retiring Councilor, Thirteenth District

The Council voted its appreciation to Dr. Rogers, retiring councilor of the Thirteenth District, both for his services as a councilor and as general chairman in charge of arrangements for the Michigan City session.

Midwinter Meeting, Indianapolis, December 1, 1932

All thirteen members of the Council were present, along with one councilor-elect, the retiring president, the president for 1933, the president-elect (1934), the treasurer, the editor of THE JOURNAL, the members of the Executive Committee, two members of the editorial board, the attorney of the Association, and the executive secretary.

Introduction by Dr. Alexander

Dr. Alexander, the chairman of the Council, reported that the editorial board had had its first meeting the previous evening at the headquarters office and the members of the board were introduced to the Council.

Reports of Councilors and Officers

Informal reports of councilors showed medical organization throughout the state in excellent condition.

Reports of officers received.

New Location of Headquarters Office

Formal report made to the Council that the headquarters office had been moved to 1021 Hume Mansur Building with additional room for publication of THE JOURNAL.

Contract Between Editor and Council

Formal contract prepared and signed by Dr. E. M. Shanklin, editor of THE JOURNAL, and the Council.

French Lick Convention Report

Preliminary report upon the arrangements and accommodations for the annual session at French Lick September 25, 26, and 27, received by the Council.

Membership Report

Membership report for 1932 showed 2,712 members as against 2,757 for the same period the preceding year.

Certificate of Merit Presented to Dr. Graham

Certificate of merit presented to Dr. A. B. Graham, past president of the Association, by Dr. Alexander.

Representative from American Society for the Control of Cancer

Dr. F. L. Rector, of the American Society for the Control of Cancer, spoke upon the possibilities of making a cancer survey in Indiana. Matter tabled for the present.

Veterans' Hospitalization

Dr. Crockett made a report upon veterans' hospitalization program and spoke of the fact that the representatives of the American Legion and the American Medical Association had met and had many viewpoints in common. He expressed the hope that some definite action might come as a result of the meetings between the American Medical Association and the American Legion representatives. (Later, as everyone knows, the order of President Roosevelt eliminating expenditures of governmental funds for non-service connected disabilities has solved this problem, at least for the present.)

Medical Registration Fee

Special committee appointed to study this subject.

Admittance of Patients to University Hospitals

A letter written by Dr. E. T. Thompson, administrator of the Indiana University Hospitals, brought to the attention of the Council. This matter brought to the attention of the Legislative Committee for study and action. (Sponsored by the Indiana State Medical Association a bill was introduced in the 1933 legislature, was passed and has become a law making it optional for the local judge to send cases of indigent minors to county hospitals instead of sending them to the Riley Hospital. Previously it was mandatory that such cases should be sent to the Riley Hospital.)

Reduction in Number of Medical School Graduates

Matter referred to the Committee on Medical Education and Hospitals. A resolution in regard to this was passed at the Milwaukee meeting of the American Medical Association.

Comprehensive Study of Health Insurance

Special committee appointed to do this work.

Elections for 1933

Dr. William H. Kennedy and Dr. H. H. Wheeler of Indianapolis were re-elected members of the Executive Committee for 1933. Dr. O. O. Alexander of Terre Haute was unanimously re-elected chairman of the Council.

Respectfully submitted,

O. O. ALEXANDER, M. D.,
Chairman of the Council.

First Councilor District

The Councilor for the First District has to report considerable absence from duty in the last few months. Remarkable as it may seem, the medical organization of the district has prospered quite as well, and maybe better, than usual.

The Gibson County Medical Society entertained the District Society at the Princeton Country Club on May 11th. Everyone felt that this was a very successful meeting from every standpoint. We look forward with pleasure to our annual meetings. Business does not interfere much with entertainment, but we do our work and have a good time in addition.

On the whole, organized medicine has had a good year in the First District.

JOHN H. HARE, M. D.,
Councilor.

The Second Councilor District

District organization is active. County Societies are intact. Membership stands at a loss.

District meeting in 1932 was held at McCormick's Creek State Park. Owen County acted as host. Attendance was good.

District meeting in 1933 will be held at Bloomington, Monroe County, September 13th. At this meeting the district councilor for the next three years will be named. Record attendance and interest is expected.

H. C. WADSWORTH, M. D.,
Councilor.

Third Councilor District

The Third District as a whole and the individual county societies composing it, report an extremely active and successful year. The fall meeting was held in Bedford and was attended by the officers of the State Society. The spring meeting was held at French Lick where preparations were made to entertain the members of the State Society this September.

No special matters have occurred requiring official notice and we feel that no district in the state has a more loyal membership in the county and state society.

H. C. RAGSDALE, M. D.
Councilor.

Fourth Councilor District

The Fourth District Medical Society held its annual meeting in Seymour, May 17th. The meeting was well attended and an interesting program was enjoyed by the members.

The officers for the ensuing year are: Dr. R. L. Compton, Osgood, president; Dr. J. C. Elliot, Guilford, president-elect; and Dr. M. Joseph Coomes, Versailles, secretary. Ripley County was chosen as the meeting place for 1934. The meeting will probably be held in Osgood.

During the past year there has been quite a bit of activity on the part of various societies in the District, notably Ripley, Bartholomew and Decatur. Ripley County has had some very interesting meetings and have been inviting the surrounding counties to participate with them. Bartholomew and Decatur have also had some very interesting meetings which have been well attended by the members of their local society as well as guests from the surrounding societies.

H. P. GRAESSLE, M. D.,
Councilor.

Fifth Councilor District

The various component county societies of the Fifth District have all been functioning normally during the year and the membership of the district is approximately up to the membership of last year.

The spring meeting of the district was held on May 5th, at the Deming Hotel. Drs. William H. Allen, Virgil E. Simpson, James H. Pritchett and Frank P. Strickland, of Louisville, Kentucky, addressed the meeting.

The second meeting of the year was held at Barbour Hill near Terre Haute. At this time the following officers were elected:

Dr. W. D. Gerrish, Clinton, president; Dr. J. R. Bloomer, Rockville, vice-president; Dr. James V. Richart, Terre Haute, secretary; Dr. O. O. Alexander, re-elected, councilor for the term beginning January 1, 1934.

Following the business session, Dr. O. N. Torian and Dr. Louis Segar, of Indianapolis, explained to the society the new plan of Child Health organization.

O. O. ALEXANDER, M. D.,
Councilor.

Sixth Councilor District

There are but two things to report from this district this year. The first is the meeting of the Sixth District society held at Greenfield, on Thursday, May 25th. This was a larger and more interesting meeting than usual. Several valuable papers were read and much interest was shown in them. All of the papers were by physicians living within the district, this being the rule in this district. At this meeting, a motion was unanimously adopted urging the election of Dr. W. C. McFadden, of Shelbyville, for president of The Indiana State Medical Association. The next meeting will be held in Newcastle on Thursday, May 31, 1934.

The other event of particular interest was the post-graduate course held in Richmond on Thursday, June 1st. As the program has already been given in the JOURNAL it is unnecessary to repeat it here. There was an attendance of about 100 and much interest was manifested in all the papers. I am sure that the success of this post-graduate course fully justifies the State Association in putting on more of them in other parts of the State.

SAMUEL KENNEDY, M. D.
Councilor.

Seventh Councilor District

Despite the effect of economic conditions, membership in each of the three counties of the Seventh District has been very well maintained and regular meetings of the local societies were successfully held during the past year. Most of these meetings were devoted to the usual presentation of scientific subjects but the trend toward group and contract practice in organized medicine is pervading this District, particularly in Indianapolis, with the result that two or three regular meetings were given over exclusively to guest speakers and general discussions of this very grave problem.

By far the greater majority of the District membership realizes that an insidious evil is at work which if permitted to continue will in time completely destroy the medical profession and all of the noble attainments for which it has always stood. Efforts are being directed by these members and local officers to prevent a few of the misguided members from being stampeded by high-pressure sales talks both within and without the profession, but principally without, into deserting organized medicine. It is pointed out by them that this plan is not only directly opposed to the ethics of medicine that has withstood the stress of all previous opposition of every description, but that in those localities in this country and in foreign countries where it is in operation it has definitely failed.

Upon substantial information attention is directed to the vicious practice of underbidding and price-cutting in order to control the volume of work. As the result of this determination to rule or ruin, professional fees have sunk below the wages of skilled workmen. Salaries or monthly incomes in many instances take the place of professional fees and with the exception of a few physicians who happen to be on the "inside" of these groups directing the work, the outside doctor taking orders is scarcely able to make a living.

It is difficult to understand the reasoning of physicians who to outward appearances always supported organized medicine and who are now apparently seized with panic and advocate a plan of practice that has completely disrupted the profession wherever it has been tried.

The long-continued depression has brought losses as well as hardships to all businesses alike. Mergers have resulted to withstand the assault of this long depression. Private business concerns with decreasing business earnings and the little fellows operating an independent business have either given up the unequal fight through inability to operate with continued losses or have been unable to expand and are maintaining their business within limited budgets.

Most physicians are "little fellows" who operate their business independently but seek organized medicine for protection. It cannot give them financial assistance but indirectly it can materially assist them by preventing these medico-lay groups with power and capital behind them from forcing them entirely out of practice or offering them the alternative of working at minimum fees or for small incomes fixed by the directors of these groups.

Impassionate pleas have been made by speakers before the Indianapolis Medical Society to halt the precipitate decision of panic-ridden physicians who can only see the salvation of their families and themselves during this depression by sacrificing their professional standing as well as ultimately a livable income.

To the members of the profession who remain loyal to organized medicine, there will be a successful way out of their present predicament with honor and respect to themselves and a return to a practice worth while. To the men who deliberately violate medical ethics and plan the overthrow of organized medicine for their own gain, contempt from both physicians and public alike is a mild condemnation.

L. A. ENSMINGER, M. D.,
Councilor.

Eighth Councilor District

The only matter of importance that has come up in the Eighth District has been concerning the rejuvenation of the District Medical Society as a separate meeting. Some men in the district have suggested that we should have a special meeting with banquet and election of officers as in other

districts, but communications from the county units voting on the proposition have voted against it. It has been suggested and seems a desirable means of settling the matter to have one or two night meetings a year at Anderson and Muncie, and have the district sponsor the night meeting as such and merely supply a program instead of the county society. All-day and evening meetings have proven an expensive failure in this district in the past, but a special district meeting with a good dinner before and a good program afterward would probably get a worth-while response.

M. A. AUSTIN, M. D.,
Councilor.

Ninth Councilor District

The affairs of the Ninth District moved very smoothly during the past year.

The outstanding feature of the year was the entertaining, educative, and most satisfying district meeting held at Hazelden, Indiana. The Benton County Medical Society is to be complimented for the success of its efforts, most especially Dr. Turley, president, and Dr. Keef, secretary.

The scientific program was well attended and was of interest to every member. The luncheon for officers and delegates, at noon, in Mr. Ade's home, during which time Mr. Ade spoke reminiscently of his personal contacts with famous doctors he has known, was a feature seldom approached and never surpassed.

In 1934 the members of the Ninth District will be the guests of the Clinton County Medical Society.

FLOYD T. ROMBERGER, M. D.,
Councilor.

Tenth Councilor District

The three societies comprising this district have been functioning about as usual; the Jasper-Newton and the Porter County societies have been carrying on in their customary style, which means that they are among the best of the smaller groups in the state.

Lake County, now in its third year of discussion, planning, and cussing of the indigent medical relief problems, continues to flounder and really get nowhere. However, thanks to the apparent success of the proposed plan of the Governor's Relief Commission, which seems likely to be adopted locally, we may emerge from our present difficulties and again resume a normal program.

Payment of the annual dues seems not so much a problem in the other county societies as in Lake County; here we have a rather large delinquent list, wholly due to economic conditions. With the present step-up in business conditions we are anticipating a return to normalcy in our paid-up membership.

On the whole, the morale of the local profession is very good; we have gone through several years of a most trying period but are yet hopeful.

E. M. SHANKLIN, M. D.,
Councilor.

Eleventh Councilor District

No report received.

Twelfth Councilor District

All the component county societies have had very good programs in the past year. Lagrange, Steuben, Noble, and Dekalb counties are organized for scientific work as the North Eastern Indiana Academy of Medicine, meeting monthly, and securing prominent speakers with a view of obtaining post-graduate instruction. Allen County had a number of out of town speakers and very good local talent to present papers. Adams, Wells, and Whitley counties were quite active and had excellent programs.

The annual meeting of the Twelfth District was held at Lake James in May. It was well attended. The speakers were Dr. Max Balin, of Detroit, Michigan, and Thomas A. Hendricks, of Indianapolis.

E. M. VAN BUSKIRK, M. D.,
Councilor.

Thirteenth Councilor District

The county medical societies of the Thirteenth District have been functioning well during the past year. Many exceedingly interesting and profitable programs have been presented. Many speakers from the medical centers have addressed the different societies.

Our most pressing problem has been financial. We have townships and cities where half of the people have been on the dole line. A number of plans of caring for the indigent sick have been used. These were not always satisfactory to the physicians, but were the best that could be obtained from the township authorities. Several plans are in operation in the district which seem quite satisfactory to everyone concerned. It has been very gratifying to note the work and the fine cooperation that the societies have shown in working out this problem. As time goes on we believe that a better and more unified plan can be adopted which will be to the advantage of the physicians, the authorities, and the indigent sick.

W. B. CHRISTOPHEL, M. D.,
Councilor.

REPORT OF EXECUTIVE COMMITTEE

House of Delegates and Council, Indiana State Medical Association:

Gentlemen:

I. INTRODUCTION.

Only by enlarging the scope of its activities has the Executive Committee of the Indiana State Medical Association been able to keep pace with

the rapidly changing medical economic picture in the state of Indiana during the past year when in rapid succession such major objects as veterans' hospitalization, reports of the Committee on the Costs of Medical Care, group hospitalization, new and varied forms of contract practice, indigent sick relief, and the new set-up of the State Board of Health, have been painted one by one in the foreground against the clouded background of economic uncertainty. To study each problem as it arose, to determine upon a policy of action, and then to inform the profession, has placed a tremendous task upon the Executive Committee, which called for time and effort far in excess of that expended by the committee in past years. Not only has the committee held official meetings once a month as in the past but it has had any number of informal conferences and has formed itself into a "flying squadron" which during the year has covered almost the entire state, keeping the county and district medical societies abreast with the most recent developments in social and medical economics. Indeed, the president of the Association, Dr. Joseph H. Weinstein, of Terre Haute, as head of this "flying squadron," reports that he has traveled some 16,000 miles visiting county and district medical society meetings during his terms as president-elect and president. He has been accompanied most of the time by one or more members of the committee. With a conviction that this effort has not been in vain and that the Indiana State Medical Association is functioning as an active, militant organization, battling for the benefit of the public and the profession, the committee submits its report with a feeling of confidence and with high hope for the future of American medicine.

New Headquarters and Journal Office. In addition to its regular duties as an executive and administrative body and a committee for the administration of malpractice defense, the Executive Committee, representing the Council, took on the additional duty last January of being directly in charge of and responsible for the business management of THE JOURNAL of the Indiana State Medical Association. Hence, for the first time, a separate section dealing with JOURNAL affairs is carried in the annual report of this committee.

After the Council had determined that THE JOURNAL of the Indiana State Medical Association should be published at Indianapolis, the Executive Committee, acting upon instructions of the Council, and realizing that an enlargement of the headquarters office was necessary to take care of its added duties, made a complete survey of possible available locations. After thorough consideration the Executive Committee determined that the Hume Mansur Building still offered the best facilities for headquarters office space, it being centrally located in the downtown section of Indianapolis, close to the state capitol and other buildings containing state offices, and in a location most available to physicians.

When the subject of an enlarged office space was broached to the Hume Mansur Company, Mr. Paul Robinson, business manager, along with members of the committee, spent a great deal of time discussing and outlining the needs of suitable headquarters office space with the result that the new headquarters office at 1021 Hume Mansur Building contains space in addition to that offered by the old headquarters office for a committee and small library room, a storage room which was very much needed, and a JOURNAL office room. As the books which are sent to THE JOURNAL for review are to become the property of the Indiana State Medical Association, it is hoped that over a period of years a suitable library may be built up at headquarters for the use of the entire profession. At the present time some forty books have been received and reviewed by the Editorial Board of THE JOURNAL and their associates and are available at headquarters office for the use of any physician in the state. Recent copies of the various state journals and medical publications also are on file at headquarters office.

The Association has a month-to-month agreement with the Hume Mansur Company and is not tied down by a contract. This was arranged as during the year considerable interest was shown by some members of the Indianapolis Medical Society in obtaining a permanent location with meeting rooms and an auditorium which would be available for meetings of the local society and also would serve as headquarters of the State Association.

II. ADMINISTRATIVE AND EXECUTIVE ACTIVITIES.

1. *Membership Report.* Until the bank moratorium the membership of the Indiana State Medical Association was ahead of the membership for the same period of 1932. With the closing of the banks, however, the membership dues practically ceased coming in to the headquarters office for almost a month and although large gains have been made we are still running somewhat behind last year when this report was made on July 31. Whether any definite connection exists between the depression and the large number of deaths that have occurred in the ranks of the medical profession during the past two years cannot be definitely determined but the records contain the names of a number of prominent physicians whose deaths have helped thin the ranks of the medical profession during the past year.

GAIN OR LOSS IN 1933 OVER 1932

	Gain	Loss
January 31	230	
February 28		75
March 31		271
April 30		275
May 31		149
June 30		147
July 31		134

2. *Insurance Forms.* During the year the committee carried into effect the work which had been done by the special insurance committee which met with a number of the leading insurance adjusters of the state and adopted a form for the use of physicians in automobile accident cases. This form which may be signed by the patient and which may be obtained through the headquarters office follows:

Dr.:

Having requested you to treat.....on account of injuries received on the.....day of....., 193.., as a result of an accident happening at....., for which I agree to pay you a reasonable sum, I hereby authorize and permit any person, firm, or corporation, or their representatives, to pay you for all reasonable medical services required by such injuries and I agree to credit all payments so made on any settlement of any claim for damages because of such injuries.

And, further, I hereby authorize you to furnish to any person, firm, or corporation, or their representatives, such information as to.....physical condition as may be obtained in rendering such professional services and if called as a witness, to testify fully and freely in court concerning the nature, extent and result of such injuries.

Any payment so made by such persons shall not be considered as an admission of liability on the part of any person, firm, or corporation making such payment.

Dated at.....this the.....day of..... 193...

Signed in the presence of—

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3. *Contract Practice, Group Hospitalization, and Reports of the Committee on the Costs of Medical Care.* During the past year many hours have been spent by the members of the Executive Committee, both in committee assembled and as speakers before medical groups, in discussing the reports of the Committee on the Costs of Medical Care, contract practice, and group hospitalization. The Executive Committee has adopted the general policies of the American Medical Association in regard to these subjects in which the medical profession is most vitally interested at the present time. The result of this has been that whereas in other states contract practice has become a definite menace to the welfare of the public and has caused the deterioration of the medical profession, and group hospitalization plans have made disturbing inroads, today in Indiana contract practice is for the most part largely a threat and group hospitalization, despite its numerous adherents, is still to be tried in any of the leading hospitals of the state.

The New Jersey Resolution of Hospital Management. In view of the increasing number of problems that have been presented to hospitals and to the medical profession in regard to hospitals, the Executive Committee wishes to call the attention of the members of the Association to the resolutions embodying principles concerning the relationship of physicians to the hospital management which were adopted by the New Jersey Medical Society:

"*Resolved,* (1) That inasmuch as the business management of hospitals is intimately associated with the medical and surgical care of the patients (for which hospitals exist), the Medical Staff of a hospital has a right to share with the Board of Trustees the management of all matters distinctly medical and, to this end, should be represented on boards or committees or by effective mutual conferences; and

"*Resolved,* (2) That approval is hereby given to the stand taken by the Essex County Medical Society and its resolutions in support of the action of the Medical Staff of the Hospital and Home for Crippled Children; and we furthermore feel that all members of this State Society should support these principles in their personal associations with hospitals.

"The resolutions adopted by the Essex County Medical Society, and the principles embodied therein, were as follows:

"Hospitals exist principally for the medical and surgical care of the sick, which care must be in charge of competent physicians.

"Boards of Trustees of hospitals are made up of public spirited men and women who have a sincere desire to serve the community, and are banded together in order that they may make possible the service that physicians give to patients.

"Medical Staffs are made up of physicians whose relative positions on the staffs vary according as years of experience and service and their ability may have qualified them.

"Physicians, by reason of their trained and experienced knowledge of disease and its treatment, and because of their daily contact with hospitals and patients, are better qualified to understand and to solve the professional problems of hospitals; and because of their intimate knowledge of each other and of each other's work, are the only ones able to correctly judge the relative abilities of physicians.

"Boards of Trustees and Medical Staffs each have special functions, some of which are distinct. There are, however, certain functions that should be performed jointly by Trustees, who have the executive authority, and by the Staff, who have the expert knowledge. All problems connected with the essential purpose of a hospital, that is, with the service which physicians give to patients, are better understood by the physicians and should be solved jointly by Trustees and Staff; also problems connected with changes in the Medical Staff of a hospital are better understood by the physicians and should be solved by co-operation of Trustees and Staff.

"We believe, moreover, that the Senior Staff of every hospital, because of the many years of daily contact with the hospital and because of the vast amount of service that they have given to the patients of the hospital, have a heartfelt interest in the welfare of that hospital. The hospital becomes an integral part of the spiritual life of each. We believe that in shaping the administration of hospitals, physicians should have a large share, not because the physicians wish it, but because hospitals need their advice.

"We, therefore, believe that:

"(1) Medical Staffs should have adequate representation on Boards of Trustees.

"(2) We believe that there should be no change in the medical policy of a hospital without proper consultation with the Staff.

"(3) We believe that no physician who has efficiently and faithfully and loyally served on a hospital staff should be removed or demoted without proper consultation with representative members of the Staff.

"(4) We believe that the medical profession should present a united front in support of the foregoing general principles, which are in the interest of the hospitals which the profession dearly loves and of the patients whom they serve."

Warning! Once again the Executive Committee wishes to stress the fact that no plans involving contract practice or group hospitalization should be approved by any medical society until thorough study has been made of each of these plans by the county society and information in regard to these plans is sent to the headquarters office.

Condemnation of the Fellowship Hospitalization Fund of the Methodist Hospital, Indianapolis. The Executive Committee passed the following formal resolution condemning the plan of group hospitali-

zation that was up for consideration by the Methodist Hospital:

"Whereas, The Indiana State Medical Association is against group hospitalization in principle because of its inherent possibilities of detriment to the public, hospitals, and the medical profession; and.

"Whereas, The Fellowship Hospitalization Fund Plan of the Methodist Hospital of Indianapolis is not in keeping with the very comprehensive and thorough report of the Staff Committee of the Methodist Hospital against group hospitalization; therefore, be it

"Resolved, That the Executive Committee of the Indiana State Medical Association condemn group hospitalization in principle, and condemn the Methodist Hospital of Indianapolis for adopting a plan which is in its essence group hospitalization, and that the Executive Committee heartily commends the Staff of the Methodist Hospital upon its splendid statement on this subject, and that copies of this resolution be sent to:

"Dr. John G. Benson, Superintendent, Methodist Hospital; Mr. Arthur V. Brown, Chairman, Board of Trustees; LaRue Carter, M. D., President of Staff; William C. Woodward, M. D., Director, Bureau of Legal Medicine and Legislation, American Medical Association; Olin West, M. D., Secretary and General Manager, American Medical Association."

Contract Practice and Medical Ethics. The principles of medical ethics contain a section pertaining to contract practice. A comment on this section by Dr. Olin West follows:

"It is specifically stated in that section that it is unprofessional for a physician to dispose of his services under conditions that make it impossible to render adequate service to his patient or that interfere with reasonable competition among the physicians of the community. When physicians resort to distinct underbidding for the purpose of securing a contract, it would seem that their conduct could hardly be considered to be in keeping with the provisions of the Principles of Medical Ethics.

"The Judicial Council has recently decided an appeal involving a contract held by a group of splendid physicians. Under the decision of the Council, the contract was declared by the Council to be unethical because the contract was of a nature that was opposed to the public welfare."

Tri-State Hospital Association Meeting. The Executive Committee sent representatives to attend the Tri-State Hospital Association meeting, a joint meeting of Illinois, Indiana, and Wisconsin Hospital Associations, in Chicago, May 3, 1933, at which the subject of group hospitalization was discussed.

In regard to group hospitalization plans the committee desires to call the attention of the profession to a letter received from Dr. R. G. Leland, director of the Bureau of Medical Economics of the American Medical Association, which follows:

"We are not convinced that periodic payment plans for the purchase of hospital care are needed in all parts of the country. Nor are we willing to subscribe to the belief that these hospital payment plans are devoid of difficulties and dangers to the hospitals as well as to the medical profession. We have urged the greatest care in scrutinizing these plans and have always raised the questions of legality and ethics. The legality will depend somewhat upon the existing statutes in your state and the interpretation of them. I am personally convinced that these plans involve a definite question of the principles of ethics pertaining to solicitation.

"There is a tremendous amount of pressure being brought to bear on hospitals in almost all sections of the country to adopt some kind of artificial and in most instances hastily and poorly conceived plans which in my opinion will involve hospitals and the medical profession in schemes which in a few years they will wish to discard. The final decision for Indiana will of course rest with the profession and the hospitals there."

Presentation of Medical Viewpoint to the Laity on Reports of the Committee on the Costs of Medical Care. The Executive Committee has gone on record to the effect that as the Committee on the Costs of Medical Care is making no undue headway with the public, it is better for the members of the profession not to discuss this matter before lay luncheon clubs, service clubs, etc.

4. *New Set-Up of the State Board of Health.* So much has been said about this in THE JOURNAL and by the officers of the State Association at various meetings that any further comment here would be only a repetition. The Executive Committee is thoroughly convinced that this is a forward step in the interest of public health and the profession and that each county medical society should accept its responsibility in this matter and should co-operate wholeheartedly in taking charge and sponsoring the worthwhile educational health program in their respective communities. If you desire, the Indiana University School of Medicine and the State Board of Health are ready to aid your local medical society in putting on any such program sponsored by your society.

5. *State Fair Exhibit.* One of the new undertakings this year was an exhibit at the State Fair. After meeting with E. R. Hays, M. D., head of the Nebraska State Fair Health Committee, who started and has been in charge of the state fair exhibit of the Nebraska State Medical Association for six years, a similar project was started this year in Indiana. The State Board of Agriculture very kindly gave the Indiana State Medical Association an entire building for its exhibits. The following committee was appointed to take charge of the exhibit: Russell Sage, Indianapolis, chairman; R. L. Sensenich, South Bend; J. E. Ferrell, Fortville; H. P. Graessle, Seymour, G. H. Wisener, Richmond; T. B. Rice, and Gordon Batman, Indianapolis. The following organizations were represented in the Indiana building: Indiana State Medical Association; Indiana State Nurses' Association; Indiana State Dental Association; Indiana Pharmaceutical Association; Indiana Hospital Association; Indiana Tuberculosis Association, and the American Medical Association.

As this is a new project, both the State Fair Committee and the Executive Committee would like to have your criticisms, comments and suggestions, in order to guide them in their work in holding future exhibits.

6. *University Hospitals.*

(1) During the year the Executive Committee asked that the Public Relations Committee make a report upon the admission of patients to the Riley Hospital. Such a report appeared in the May JOURNAL and, in brief, states that any county society desiring information in regard to the number of patients and by whom they are referred may receive this data for any period desired by writing

to J. B. H. Martin, administrator, Indiana University Hospitals.

(2) *Use of Rooms for Private Patients in University Hospitals.* The Executive Committee instructed the Public Relations Committee to make an investigation into this matter. The Executive Committee is of the opinion that if there is anything in the law which makes it obligatory for the University Hospitals to maintain these rooms for private patients this should be brought to the attention of the Legislative Committee for action at the next session of the General Assembly.

(3) *Recent Act of the Legislature in regard to University Hospitals.* The Executive Committee wishes to call the attention of the profession to the fact that a law was passed at the last session of the legislature giving the county judge the option of sending minors to the Riley Hospital. Under this new law patients may be sent to the hospital of the county in which they reside, or that of an adjoining county.

7. *Care of the Indigent Siek.* One of the greatest concerns, not only in Indiana, but throughout the country, has been the question of rendering adequate medical services to the indigent sick upon a basis that would be fair to the taxpayers, the patients, and the physicians. The Executive Committee from time to time through bulletins and talks before district and county medical societies and through the pages of THE JOURNAL has urged local county medical societies to draw up agreements with their local trustees to take care of this work which has been done successfully in a number of localities. (This is in counter distinction to the method usually in vogue up to date of the township trustee signing a contract with an individual physician or in some cases several individual physicians to take care of this work. Incidentally, it is the opinion of Albert Stump that such contracts upon any other but a fee per case basis are illegal.)

Two years ago, Governor Leslie appointed a Medical Service Committee which made a survey of the entire state of Indiana of the amount of money paid for hospital, nursing and medical services for the indigent sick throughout the state. The figures compiled by this committee are most interesting and have to some extent formed a basis upon which township trustees and medical societies have come to an agreement in regard to fees which should be paid for medical services.

Prineiples for Medical Relief. A sub-committee of the Executive Committee was appointed to draw up general principles which would apply throughout the state and which the director of the State Relief Commission could promulgate to guide the various localities in making arrangements for the care of the indigent sick. A complete outline of these principles and rules under which R. F. C. funds may be available for certain types of medical services is given on another page of this issue of THE JOURNAL. The Executive Committee urges county medical societies to give their assistance to the district representatives of the State Relief Commission in order to perfect agreements and arrangements with the local township authorities in order to take care of the indigent sick under the general principles which have been promulgated. So far as is known by your committee, Indiana is the first state where the medical association has worked out an agreement with the state relief commission. The Executive Committee takes this opportunity of thanking Mr. Fred Hoke and Mr. William Book, in charge of state relief work, for their courtesy and broad comprehension of this very difficult subject.

8. *Question as to Whether or Not a Physician May Send a Cheek for his Dues Direetly to the State Headquarters Instead of to his County Secretary and Then Reeeive a Membership Card Direetly from the State Headquarters Without a Request Therefor by the County Secretary.* It is the opinion of the attorney of the Association that under the Constitution and By-Laws this can be done without the county society secretary's request *but not without his approval.*

III. THE JOURNAL.

Acting directly as the agent for the Council, the Executive Committee has been responsible for the business management of THE JOURNAL since January 1, 1933. THE JOURNAL affairs have taken a great deal of the time and attention of the committee and many problems of policy have been determined after due deliberation by the Executive Committee and the Editorial Board. In some cases their duties and prerogatives have somewhat overlapped but in the majority of cases the duties of the Editorial Board are distinctly those which have to do with editing THE JOURNAL while the duties of the Executive Committee have to do with the publication, business management and directing the financial affairs of THE JOURNAL. Both the Board and the Committee have worked in harmony and are striving to the best of their ability to maintain the high standing which THE JOURNAL of the Indiana State Medical Association always has held in medical publication circles. Certain definite principles governing the publication of THE JOURNAL have been laid down, the most important of which follow:

(1) Any advertising accepted by THE JOURNAL must be approved by the officers or the Co-operative Advertising Bureau of the American Medical Association.

(2) The Committee went on record against accepting advertising on a basis of returns from advertising; that is, any advertisement that is taken shall be paid for at regular space rates and not upon a commission basis.

(3) A plan whereby certain ethical drug houses may be asked to take cards in THE JOURNAL on a page devoted to such cards, was approved by the Committee.

(4) The Committee determined that cigarette advertising, properly edited, is acceptable, but although several other state journals are carrying brewery advertising, such advertising should not be carried in the Indiana JOURNAL.

The first and one of the most important duties of the committee was to select a publisher for THE JOURNAL. After obtaining the bids and analyzing them the award was made to the William B. Burford Printing Company of Indianapolis and to date the relationship with that company has been most agreeable.

IV. MEDICAL DEFENSE ACTIVITIES.

1. *Detailed Report of Malpractice Cases Handled by Medical Defense Committee.* Due to the depression the amount of time spent by the Executive Committee and the attorney of the Association in medical defense activities was increased enormously. The number of cases threatened have increased almost ten times over those brought to the notice of the Executive Committee in an ordinary year. The expenditure for medical defense alone has increased in relative proportion. The committee here wishes to express its appreciation for the help and co-operation it has received during these trying times from a number of the larger commercial companies who are writing malpractice insurance.

In giving medical defense the committee has made it a policy to be as liberal as possible in the protection of the physicians and yet keep within the limits of expenditures provided by the Constitution and By-Laws. A special effort is being made now as never before, through the attorney of the Association, to halt threatened cases before they are filed. Such efforts would be useless unless the individual physician against whom a suit is threatened will co-operate with the State Medical Association and will notify the headquarters office at once. If the individual physician carries insurance with a commercial company, he should also notify that company. Delay and loss of time on the part of the physician threatened delays these matters and may lead to serious difficulties.

A year ago, at the time of this report, August 1, 1932, the following seventeen cases were pending before the committee, eight of which have been closed, and the committee reports the following progress on these seventeen cases:

Case No. 129—Case pending since 1925. No action for several years. Probably can be dropped soon.

Case No. 151—Suit filed July, 1927. No new developments. Likely that suit will be dropped. Expense, $100.00, paid August 25, 1932.

Case No. 156—Suit filed March 27, 1928. Case tried June 7, 8, 9, 14, 15 and 16, 1933. Verdit for plaintiff. Expense, $66.28, paid September 23, 1929; $350.00, paid June 30, 1933.

Case No. 162—Case still pending. Tried in 1928 and postponed. No further developments.

Case No. 164—Case closed September 23, 1929, by dismissal of complaint by plaintiff. Expense, $150.00, paid September 23, 1929. Second suit filed October, 1929. Case was pending at time of death of defendant, October 9, 1932, which closed case. Expense, $75.00, paid January 3, 1933.

Case No. 170—Suit filed June 12, 1930. Still pending.

Case No. 172—Suit filed April 9, 1930. Still pending. No new developments.

Case No. 175—Suit filed December, 1930. Tried May, 1933. Verdict for all defendants. Expense, $200.00, paid June 30, 1933.

Case No. 176—Suit filed March 28, 1931. Still pending.

Case No. 178—Suit filed June, 1931. Case dismissed March 14, 1933. Expense, $100.00, paid May 19, 1933.

Case No. 180—Suit filed August 19, 1931. Dismissed December 6, 1932, for lack of evidence. Expense, $150.00, paid January 23, 1933.

Case No. 181—Suit filed September 8, 1931. Pending. No new developments.

Case No. 183—Suit filed October, 1931. Closed October 19, 1932, with judgment in favor of defendant. Expense, $200.00, paid January 3, 1933.

Case No. 184—Suit filed October 13, 1931. Pending.

Case No. 187—Suit filed February 13, 1932. Pending.

Case No. 188—Suit filed July 2, 1927. Case tried; verdict for plaintiff. Motion filed for new trial. Expense, $300.00, paid on June 22, 1932. Defendant died November 15, 1932, closing the case.

Case No. 191—Suit filed November 6, 1930. Four days' trial, May 26, 27, 30 and 31, 1932. Verdict for defendant. Expense, $250.00, paid August 19, 1932.

Since August 1, 1932, and up to August 1, 1933, the following seven new cases have come before the committee, three of which are closed, leaving thirteen unclosed cases on hand, a reduction of four over the preceding year:

Case No. 192—Suit filed August 9, 1932. Pending.

Case No. 193—Suit filed September, 1932. Tried December 19, 1932. Verdict for defendant. Expense, $100.00, paid January 3, 1933.

Case No. 194—Suit filed July 9, 1932. Pending.

Case No. 195—Suit filed October, 1932. Tried March 8, 9, 10 and 11, 1933. Verdict for plaintiff in amount of $500.00. Expense, $300.00, paid April 17, 1933.

Case No. 196—Suit filed September 14, 1932. The Executive Committee could not defend this case as the defendant was delinquent in the payment of his State Medical Association dues at the time he rendered the services which resulted in the suit being filed against him.

Case No. 197—Suit filed December 30, 1932. Pending.

Case No. 198—Suit filed May, 1933. Pending.

The total cost of medical defense from August 1, 1932, to August 1, 1933, was $1,825.00. The preceding year this expense was $1,980.65, and the year before that it was $450.00.

2. *Legal Opinion upon Medical Defense.* During the year Albert Stump, attorney for the Association, was asked for an opinion upon the following matter in regard to medical defense:

Right of Association to refuse medical defense to a physician who is not a member in good standing:

"The rights of members of an association are determined by the by-laws of the association. To entitle a physician to receive the medical defense of the Association such physician must conform to all of the requirements of the by-laws in regard to the defense. In the case of Dr. there was a default in the compliance with the requirements of the by-laws, according to the facts you have stated. Under the circumstances the Association could not be compelled to pay for his defense. Compliance with all of the requirements of the Association is precedent to his right to obtain the defense.

"This situation is different from the situation that develops from a failure to make a proper application or to satisfactorily conform to any of the details in the rules regulating the defense which may be made by the Executive Committee. In this case the by-laws specifically provide that under cer-

tain conditions the physician is not entitled to the defense. This is a matter which the committee itself does not control and therefore cannot waive. This distinguishes the case from those in which payment might be made after the physician had conducted his own defense not knowing he was entitled to the defense of the Association. In the latter instance he was entitled at all times to the defense but failed to claim what he was entitled to. But in Dr. case under the by-laws he had lost the right to defense during a certain period of the time that he was in arrears, as that time is fixed in the by-laws."

Testimony in malpractice cases. The question was asked whether or not there is in effect in the State Medical Association a ruling that members of the Association in good standing will testify in malpractice suits without charge. The members of the committee are not familiar with any such agreement. However, the committee is of the opinion that unquestionably there is a courtesy understanding among members of the profession by which many physicians gladly assist their fellow practitioners without charge, but this is entirely up to each individual man and each individual case to use his own pleasure.

V. CONCLUSION.

In addition to these many major problems your committee has discussed and acted upon many minor problems included among them disputes in regard to memberships, actions of county societies against physicians for one cause or another; it has reviewed protests, resolutions and motions which have been referred to it by local county medical societies upon membership and organization problems and has done many odd jobs seemingly of minor importance but nevertheless jobs that had to be done. We have given information and data which has aided in preparing cases which have been brought against quacks; we have supplied new charters to county societies which have lost their old ones; in short, we have tried to be of service to the profession and the public in every way within our power and abilities.

Respectfully submitted,

WILLIAM H. KENNEDY, M. D., Chairman.
H. H. WHEELER, M. D.
J. H. WEINSTEIN, M. D.
E. E. PADGETT, M. D.
O. O. ALEXANDER, M. D.

REPORT OF COMMITTEE ON LEGISLATION AND PUBLIC POLICY

House of Delegates, Indiana State Medical Association:

Gentlemen:

I. INTRODUCTION.

So far-reaching has been the legislation and the changes in government in both state and nation during the past year that it is most difficult for your Legislative Committee to make a comprehensive report for this period. In fact, so many important and perplexing problems which were not foreseen when the legislation itself was passed have sprung up and so many new developments are taking place every day as the result of the broad administrative powers both in the state and nation that it is difficult to know where this report should start and where it should stop.

Usually when the state legislature and congress adjourn, a complete appraisal and final report of legislation of particular importance to the profession can be made, but this year no such definite accounting can be recorded as the full effect of many of the statutes enacted will not be felt until they have been in operation for some time, as more depends upon the way the laws are administered than upon the contents of the laws themselves. A complete, detailed report of the Legislative Committee was printed in the April JOURNAL (pages 187-191) following adjournment of the last session of the general assembly, and it may be well to recall that twenty bills affecting the members of the medical profession directly or indirectly were passed and signed by the governor, and one bill of this character became a law without the governor's signature. The April report of the committee should be included as a part of this present summary. It may be well to consider some of the principal problems that have arisen as a result of this legislation since the report in April, although many of them are dealt with in detail by other committees.

II. OF STATE INTEREST.

New Set-up of State Board of Health. This new set-up which resulted with the elimination of the old child hygiene department that cost the state almost eighty thousand dollars a year and was considered unnecessary by many members of the profession, has placed many added responsibilities upon the county medical societies. As a result of this legislation, for the first time the Indiana State Medical Association, the Board of Health, and the Indiana University School of Medicine all are working in conjunction on a program of education in the interest of the children and parents of the State of Indiana.

Maintenance of the Present Status of the State Board of Medical Registration and Examination. Despite desperate efforts by the cultists both during the session and since the adjournment of the legislature to upset the present medical laws and tear down the standards of medical practice by which the public is protected, the present status of the State Board has been maintained. During the session the chiropractors tried to create a separate board. Failing in this, it is understood that they have been beseeching the governor to cut the present medical board to three members, to be composed of one chiropractor, one drugless healer, and one regular physician. The governor has given his assurance that such action will not be taken and the present board will not be dominated by minorities but will remain as at present constituted

with the various schools of the healing art represented.

Riley Hospital Patients. A measure which did not receive much attention at the time of its passage, but which has proved to be both practical and popular, was the measure which authorized a judge to commit to any public hospital in the county or to a hospital in an adjacent county, any indigent minor who is suffering from disease. This means that judges now have the option of sending cases of this character either to the Riley Hospital in Indianapolis or to their own county hospital or that in an adjacent county.

III. OF NATIONAL INTEREST.

Veterans and National Economy Acts. The Legislative Committee takes this opportunity to express the pride which it feels in the part that the Indiana profession played in the final enactment of the national economy act which cut out allowances for veterans' *non-service*-connected disabilities. The testimony given by the representatives of the State Association at the hearing more than a year ago before the Shannon Committee had a great effect upon the legislation that finally was enacted.

Right of the Physician to Prescribe Medicinal Whisky. With the repeal of the Wright Bone Dry Law in Indiana and the liberalization of the Federal statute, the right of the physician who desires to prescribe and use whisky for medicinal purposes seems to be adequate. No violations of the law by physicians have been reported to the Legislative Committee or the officers of the Association.

National Recovery Act. As this report goes to press, no code has as yet been drawn up by the American Medical Association to cover the medical profession. It is understood that physicians, nurses, and technicians are exempted from the provisions of the blanket code. There seems to be some question as to how the act affects physicians' office girls and bookkeepers.

IV. CONCLUSIONS.

We wish to take this opportunity to thank the many friends of the profession who were holding public office and who were members of the last general assembly who supported whole-heartedly those measures of interest to the public health. Particularly we wish to thank the members of the public health committees of both the House and the Senate for their broad vision and careful study of the numerous bills which, had they become laws, would have been detrimental to the public welfare.

In this brief summary no account has been taken of the tremendous social and economic changes that have taken place as a result of the recent legislation, both state and national. Just what the effect will be upon physicians as citizens, as individuals, and upon the profession as a whole, no one can foresee. Your Legislative Committee, however, hopes that your House of Delegates will see fit to recommend a continuance of the militant policy adopted by the Indiana State Medical Association in combating and, insofar as possible, controlling forces which would enact laws that are inimical to the public welfare and against the high standards of the medical profession. To this end, we urge every physician in the State of Indiana and every county medical society to take an active interest in the political life of the community, the state, and the nation. We feel that if the interests of the profession and the public are to be guarded in health matters, that the medical profession of Indiana should be well represented both in the House of Representatives and in the Senate of the General Assembly.

Respectfully submitted,

GEORGE DANIELS, M. D., Chairman.
F. H. JETT, M. D.
J. W. WRIGHT, M. D.
L. J. DANIELESKI, M. D.
L. E. FRITSCH, M. D.

REPORT OF THE EDITOR OF THE JOURNAL

House of Delegates, Indiana State Medical Association:

Gentlemen: In presenting our first report concerning THE JOURNAL we are conscious of many things, chief of which is the debt we owe to so many of our members for their most timely aid and assistance. Without being too specific, we may mention, first, the Editorial Board. That the Council acted most wisely in providing for the election of such a board is evidenced by the support which the editor has received from this group; our deepest appreciation for this help is hereby expressed.

In passing we would like to make the observation that in our opinion the better state medical journals are those which have editorial boards; the few remaining journals that are under one man control certainly do not compare with the other group.

We are disposed to let THE JOURNAL speak for itself; not that we are entirely satisfied with it in its present state, but because the membership at large has had eight months in which to judge our efforts to carry on the work. In our maiden editorial we confessed our timidity in assuming the position so long held by the late and lamented Dr. Bulson; we were well aware of the task that lay before us; we knew that without material assistance we could not hope to accomplish much. We did not wish for such assistance in vain; our fellow members have been most generous in their support, both by words of encouragement and by sending in material to be used.

Nor should we forget the assistance we have received from headquarters; both Mr. Hendricks and Miss Toman have carried on the many tasks assigned them in a most efficient manner. Of one

thing we are most firmly convinced, and that is that THE JOURNAL should be published from headquarters.

Meetings of the Editorial Board have been held about every three months; it might appear that these conferences should be held oftener, but we are compelled to save every possible expense.

We have had many comments about THE JOURNAL, some of them constructively critical, many of them commendatory, and all of which have been most pleasing to us. As we have frequently said, we court criticism, when offered in a friendly, constructive manner, for by such means we are enabled to improve THE JOURNAL.

One suggestion we would repeat is that we do not hear enough from our county societies; if we could but have an occasional letter from our secretaries we are sure that we would be able to make our editorial and news notes more interesting to our Indiana readers. Very frequently we have to depend on press reports for professional news that is decidedly interesting to the average physician.

For many years there was heard considerable criticism that books sent in for review found their way into private libraries; one of the first of the new rules set forth by the Board was that all books reviewed became the property of the Association. In this manner we will, in a few years, build up a good working library. Most of the reviews, for the present, are made by Board members.

The financial report for THE JOURNAL will be made in January.

In conclusion, we again thank the members of the Indiana profession for the generous support we have received, and we trust that the remaining issues of THE JOURNAL for 1933 will continue to merit your approval.

Respectfully submitted,

E. M. SHANKLIN, M. D.,
Editor.

REPORT OF THE BUREAU OF PUBLICITY

House of Delegates, Indiana State Medical Association:

Gentlemen:

I. INTRODUCTORY REMARKS.

The Bureau of Publicity of the Indiana State Medical Association occupies a most unique position in medical organization work throughout the country. Many of the societies and state associations in the country have committees on publicity and public relations but only a few of these committees devote as much as one afternoon a week throughout the year to this work and function in as continuous a fashion as does the Indiana Bureau of Publicity.

A well-known advertising axiom is that in order to be effective a name, a trade mark, or a message, must be repeated over and over again, perhaps each time in a different manner but always with the same object in mind. Following this axiom, since its foundation in 1923, the Bureau of Publicity has prepared releases for the daily and weekly press of Indiana upon health subjects, and for ten years has brought home to the public of Indiana one message: "In case of sickness, go to your family physician." Not only through the press but by talks before luncheon clubs, chambers of commerce, and lay organizations, speakers appearing upon behalf of the Bureau of Publicity have spread this message throughout Indiana. As a result of these ten years of service a feeling of confidence has been developed by the newspaper editors and by the public that if the Bureau of Publicity makes a statement they can rest assured that such statement can be relied upon.

Meeting as it does once a week, the Bureau of Publicity has made it possible for the public to receive information upon medical subjects with the least possible delay. The services of the Bureau have been available to the profession and to the public every working day, every week of the year. The profession of Indiana, through the Bureau of Publicity and through the organization of the Indiana State Medical Association, has been able to seize opportunities which otherwise would have passed by. One of these in particular occurred last summer when the Shannon Congressional Committee invited the Indiana State Medical Association to send speakers to its hearing in South Bend to present the viewpoint of the Association upon the question of government competition in private medical practice. This invitation came only a few days before the hearing and through the Bureau of Publicity a speaking organization was perfected to present the viewpoint of the Indiana profession at this hearing. The outcome of that hearing is now history, and the profession may be justly proud of the fact that upon the information received during the hearing here in Indiana, during similar hearings in several other states, and from the American Medical Association, the Shannon committee made the recommendation that resulted in the drastic cuts President Roosevelt made in the appropriations to ex-service men for non-service connected disabilities.

II. UNOFFICIAL OPINIONS OF THE BUREAU.

1. Due to its unique position in being neither a legislative nor an administrative body the Bureau of Publicity often has functioned in an unofficial capacity in giving opinions on medical ethics which, had they been promulgated by an administrative or legislative group of the Association, undoubtedly would have caused serious difficulty. Throughout the country many insurance schemes have been developed both for group hospitalization and for medical services. In several communities outside of Indiana these schemes have torn societies asunder and undoubtedly will leave their marks for years to come. Acting in its unofficial capacity the Bureau on many occasions has considered such

questions and by unofficial action has avoided a rift in the profession in several localities in the state. In one community the physicians presented a pure case of insurance contract practice to the Bureau which, had it been instituted, undoubtedly would have proved unsatisfactory and assuredly would have caused much friction among the local profession. Had such a matter been brought before a legislative, administrative, or judicial committee of the Association, rulings might have been made, resolutions passed and judgments handed down which would have been embarrassing to the parties involved.

2. *Talks Before the Laity.* The opinion of the Bureau has been asked as to the advisability of the members of the profession speaking to the lay public on the majority and minority reports of the Committee on the Costs of Medical Care. The Bureau feels that the statement made by the president of the State Association, when his opinion was asked regarding the policy concerning these talks, is sound, and the Bureau wishes to uphold that statement.

"I still feel that we should definitely stand on the ground that we adopted in regard to lay publicity on the majority report. It is not creating any sensation among the public, and I think we are more likely to bring it to their attention by our efforts of antagonism than by silence. If these civic clubs want the doctors to talk to them on the economic conditions of the medical profession, it can be done without bringing in any mention of the majority or minority report, and yet lay before them our position in regard to the care of the indigent, public health and the cost of medical care. Let's discourage this practice as much as possible."

3. *Radio Broadcasting Rules.* Many county societies have sponsored radio talks upon medical subjects and have inquired from the Bureau of Publicity as to whether or not a physician who is making a radio broadcast should be introduced by his name. The Bureau made a statement in regard to its ruling governing broadcasting in its annual report to the House of Delegates, September, 1929, and herewith states that rule again: The Bureau has adopted a rule that no physician who is in private practice should have his name mentioned over the radio in connection with the Bureau of Publicity broadcasts. The names of physicians holding public office and connected with public institutions may be mentioned over the radio when they are speaking in an official capacity.

III. Stand of Bureau Against Fee Splitting and Rebates.

The Bureau once again takes this opportunity to re-state the stand it has taken against the practice of fee splitting and rebates. During the year the following letter was received from a physician in Indiana:

"Today a representative druggist of this town approached me with a proposition to give me a rebate of 25% on all trusses or similar garments sold to my patients by direct reference. He said (when I told him I wouldn't be interested in the 25%, that it should go to my patients) that Doctor ———— certainly puts their names down and collects.

"Now the surprising thing to me is not that I was offered this proposition, because I have encountered it before, but the doctor is quite prominent and has apparently a soul of virtue. Also, I do not believe that this druggist really realized that he is doing a very unethical thing. I believe they should have a letter as they are the most representative Rx druggists in this town and the situation should be explained to them in a very authoritative manner.

"I know that you have been having trouble with this sort of thing but did not think it was occurring in this town, that is, until today, when I find I have been in the dark, as we frequently find ourselves in matters such as these.

"Any way I can help your committee in this matter I will be glad to do so."

The stand of the Bureau of Publicity in this matter is shown in the following letter which was sent in answer to the above:

"Your letter of June 17 to Dr. Wishard was referred to the Bureau of Publicity of the Indiana State Medical Association at its regular weekly meeting June 27.

"The Principles of Medical Ethics of the American Medical Association are specifically against such practices as described in your letter, as you can see from the following excerpt:

" 'It is unprofessional to receive remuneration from patents for surgical instruments or medicines; to accept rebates on prescriptions or surgical appliances, or perquisites from attendants who aid in the care of patients.'

"The Bureau of Publicity feels that it is your duty to notify your local judicial council of this situation, and the Bureau suggests that the council invite the druggist in question to appear before it. It should be explained to the druggist that the proposition he made to you is unethical. It is suggested that your local council also state that the Bureau of Publicity of the Indiana State Medical Association will refrain from publishing the name of the druggist in question if your local society approves of such restraint on the part of the Bureau of Publicity. The Bureau, however, suggests that the druggist should be warned that a repetition of this abuse will lead to more drastic action.

"The Bureau wishes to thank you for calling this to its attention, and you may be sure that the Bureau will stand behind you and the council of your local society in any reprimand it thinks should be made in this matter. If anything in this letter is not clear and if you have any further question, do not hesitate to write us. Such practices as outlined in your letter are most reprehensible and are neither in the interest of the profession nor the public, and it is the duty of the profession in your county to guard the public against such abuse."

IV. Historical Work of the Bureau.

1. *State Historian.* In 1929 the House of Delegates in the following resolution authorized the Bureau of Publicity to prepare ways and means for writing a medical history of Indiana:

"Whereas, Secretaries, past and present, are to be commended for their efforts to preserve matters of historical interest to the Indiana State Medical Association, and

"Whereas, It is difficult or impossible to compile a History of Medicine in Indiana unless some systematic method is adopted for that purpose,

"Therefore Be It Resolved, That the Committee on Publicity of the Indiana State Medical Association be requested to establish Archives of Medical History of Indiana and that this committee recommend to the House of Delegates the name of a member of the Indiana State Medical Association as Historian, and that the appointment of such Historian shall be permanent

when so elected by the House of Delegates until removed by death or has become incapacitated from other causes and that, thereafter, when a vacancy occurs in this office, it shall be filled by nomination by the president of the Association and election by the House of Delegates."

Since this resolution was passed the Bureau of Publicity has gathered a great deal of material from many sources, but not until this year has work upon the history actually been begun by Dr. Leon G. Zerfas of Indianapolis, who was named historian by the Bureau of Publicity, and whose appointment was approved by the House of Delegates at the Michigan City meeting. The letter giving the plan adopted by the historian for preparing this history follows:

"Since I last saw you, I spent a day and a half in the Transylvania Library at Lexington. I now have a complete list of men from Indiana who either attended lectures or received the M. D. degree there from the time the first class was graduated. Also, I read and abstracted the important theses prepared as a requirement for their graduation. The man who heads the list is an Indiana man.

"I noticed that Doctor Samuel Mitchell received an honorary M. D. degree from Transylvania in 1830; likewise, Doctor Livingston Dunlap. Doctor Cornet, the first President of the Indiana State Medical Association, was also a graduate. There were about seventy men from Indiana who graduated there, and, of course, a considerable number of men from other states who graduated from there and who settled in Indiana. It will be more difficult to compile a complete list of the latter group.

"Since we have this rather long span of years before our own medical institutions cut much of a figure in medical education, it seems to me that it will be absolutely necessary to make a comprehensive study of medical education from about 1800 to 1850 and later, as it was carried on in the adjoining states and schools from which our early physicians were graduated. Of course I realize that many did not graduate from any school except that of experience, but frequently they were trained, even then, by graduates of the various leading institutions.

"It is perfectly astounding that so much material can be found concerning the status of education over this period of time. The library facilities for the old books are so poor in Indianapolis that I shall have to do much of the work in the Transylvania Library, in Louisville, Cincinnati, and Philadelphia. If I only had the sources of material near at hand it would be wonderful, but as it is, I shall have to catch the time as best I can.

"I have not yet formulated a definite list of chapters for the book, but I have a general plan in mind for a series of articles to be published in the Journal on medical education, which will undoubtedly constitute an important phase in our medical history. Let me have your views. My idea was:

"1. To give a resume of the status of medical education from about 1800-1830. I have much information on this subject written by authoritative authors, and, in addition, the articles published in the journals which reflect the status of education. I have the medical school requirements in the nineteen leading schools in the United States, many of which supplied our state with graduates. I thought some short discussion of the leading teachers might also be worthwhile.

"a. Translyvania graduates, with list of their theses. (Men from Indiana.)
"b. Ohio Medical College—a list of Indiana medical students and graduates yet to be obtained.
"c. Louisville School.
"d. University of Pennsylvania.
"e. Maryland.

"2. To present a complete bibliography of all published papers by Indiana men as determined by a careful study of the journals covering the period 1800-1850. There were some twenty journals up to 1830. I have already found several articles published shortly after 1820 by Indiana physicians.

"3. To discuss type of diseases, epidemics, and so forth. I have collected considerable information on this beginning as early as 1788 in the Northwest Territory."

The Bureau asks the co-operation of all members of the Association and all medical organizations in Indiana in aiding Dr. Zerfas in this important task by forwarding either to the headquarters or to Dr. Zerfas any material that may be of historical value.

2. *Dr. Frank B. Wynn.* Upon the request of the director of the Scientific Exhibit of the American Medical Association, a photograph of the late Dr. Frank B. Wynn, who organized and presented the first scientific exhibit in connection with the annual meeting of the American Medical Association, was sent to the headquarters of the American Medical Association. At the same time a short account of Dr. Wynn was prepared by the chairman of the Bureau and forwarded to the American Medical Association.

3. *The Oldest Medical Book in Indiana.* "The Indian Guide to Health for the Cures of all Disorders Incident to This Climate," by Dr. S. H. Selman, of Columbus, Indiana, published in 1836, is undoubtedly one of the oldest medical books in the state. It shows that therapeutics in those days were not comparable to our present methods. It deals chiefly with concoctions prepared from herbs and roots.

Before this book was brought to the attention of the Bureau, Indiana's oldest medical book was thought to be "A Practical Treatise on Diseases Peculiar to Women and Girls," by Dr. Buell Eastman, published in 1845. If anyone knows of a book antedating these two the Bureau of Publicity will be very pleased to receive information.

4. *Historical Sketches.* The Bureau wishes to express its appreciation for two very interesting historical sketches which have been received during the year, the first one in regard to the one-hundredth anniversary of the profession in Wabash County, by Dr. J. T. Biggerstaff, and the second one an account of early medical practice in Hendricks County by Dr. W. T. Lawson.

V. Pamphlet Prepared by the Bureau.

The Bureau of Publicity prepared 10,000 pamphlets entitled, "Information Regarding the Prevention of Contagious Diseases." Copies of this pamphlet were sent to the officers of the Association, the secretaries of the various county medical societies, and many copies to laymen requesting it. This pamphlet is prepared for distribution to the laity and any physician desiring copies of it may obtain them by writing to the headquarters office, 1021 Hume Mansur Building, Indianapolis.

VI. Activities of Vivisection Investigation League Against Bureau of Publicity.

The Vivisection Investigation League of New York City has been very active in the last year in attacking several articles sent out by the Bureau of Publicity advocating vaccination and pointing out the benefits of immunization in typhoid fever, smallpox, and diphtheria. A revelation of the methods employed by the Vivisection League has been made by the Bureau of Health and Public Instruction of the American Medical Association. These complaints against the Bureau's articles are signed by Sue M. Farrell, president of the Vivisection Investigation League. Complete details in regard to the methods used by the League may be obtained by addressing Dr. W. W. Bauer, director of the Bureau of Health and Public Instruction, American Medical Association, Chicago, Illinois.

VII. Nostrum Warning.

The Bureau wishes to call the attention of the profession to the recent growth of popularity of a number of nostrums such as Crazy Crystals, Peruna, etc., which claim to have certain health giving properties and by indirect or direct advertising lead the public to believe that these products can do more to cure than they can be depended upon to do. The Bureau emphatically condemns the American radio for blatant advertising of such products.

VIII. New Set-up of the State Board of Health.

The Bureau of Publicity goes upon record approving the new set-up of the State Board of Health and the new plan for child health education. The Bureau realizes that a considerable task, but a task which is an obligation for the local medical societies to perform, has fallen on the medical profession of every county.

IX. Annual Congress on Medical Education and Licensure, Chicago.

The Bureau of Publicity sent a representative to the Annual Congress on Medical Education and Licensure which was held in Chicago February 13 and 14. This representative placed the following resolution, upon behalf of the Indiana State Medical Association, before the Congress:

"It is the view of the Bureau of Publicity of the Indiana State Medical Association that the pre-medical requirements for licensees should be more thorough. There are more applicants for licenses than are required to supply the public need. We believe that a basis of preparation for the study of medicine is best secured by a thorough cultural training and this will tend helpfully to improve the personnel of the medical profession and to discourage those unwilling to take proper pre-medical training."

X. Speaking Engagements.

During the past year the Bureau of Publicity has supplied many speakers for both medical and lay meetings. Following is a list of meetings for which the Bureau supplied one or more speakers but this list is not inclusive as the Bureau of Publicity was either directly or indirectly responsible for obtaining speakers and arranging programs for numerous other meetings to which the speakers actually were invited not through the Bureau, but through the local county medical society officials:

1932

Sept. 12—Gibson County Medical Society, Princeton.
Oct. 11—Fayette-Franklin County Medical Society, Connersville.
Oct. 13—Kiwanis Club, Connersville.
Nov. 14—Gibson County Medical Society, Princeton.
Dec. 14—Ripley County Medical Society, Osgood.
Dec. 16—Knox County Medical Society, Vincennes.

1933

Jan. 5—Clinton County Medical Society, Frankfort.
Jan. 12—Hancock County Medical Society, Greenfield.
Jan. 17—Delaware-Blackford Medical Society, Muncie.
Jan. 19—Montgomery County Medical Society, Crawfordsville.
Feb. 22—Hamilton County Medical Society, Noblesville.
Mch. 17—Owen County Medical Society, Spencer.
Mch. 23—Wayne-Union County Medical Society, Richmond.
Mch. 28—Grant County Medical Society, Marion.
Apr. 6—Fountain-Warren Medical Society, Kingman.
Apr. 14—Floyd County Medical Society, New Albany.
May 3—Bartholomew County Medical Society, Columbus.
May 3—Lawrence County Medical Society, Bedford.
May 10—Third District Medical Society, French Lick.
July 10—Kiwanis Club, French Lick.

XI. Newspaper Releases Published Since Last Report of Bureau.

Children's Teeth in Vacation Time (dental release).
Defines Tooth Decay (dental release).
Preparation of Children for School.
Lurking Tooth Ills Revealed (dental release).
Annual Session of Indiana State Medical Association at Michigan City (8 releases).
Hoosierland's Health Harvest.
Trouble-Making Habits (dental release).
A Word to Hunters.
Laxatives and Appendicitis.
Campaign against Appendicitis.
Health Resolutions.
Sinus Trouble.
Disease Prevention Pamphlet.
Business Lectures for Medical Students.
Teeth and Taxes (dental release).
Dental Research in Relation to the Child (dental release).
Healthy Days Are Here Again.
Vacations and Typhoid.
Keep Your Eye on the Ball.
Post-graduate Course at Richmond, Ind.
Causes of Illness.
New Set-Up of State Board of Health.

These releases were distributed as follows:

1. Eight hundred and twenty-five to Mrs. Edna Hatfield Edmondson, executive secretary of the Indiana Congress of Parents and Teachers and field worker of the Extension Division of Indiana University. These releases are distributed to the parent-teacher associations and women's clubs of the state during the fall, winter and spring months. The Bureau wishes to thank Mrs. Edmondson, the Parent-Teacher Association, and Indiana University for their splendid help and co-operation.

2. Fifty to Miss Eva F. MacDougall, director of the Division of Public Health Nursing of the Indiana State Board of Health. It is with special pleasure that the Bureau of Publicity thanks Miss MacDougall and the public health nurses' organization for their interest and help in the distribution of these releases.

3. Fifty to the State Director of the Department of Health of the Woman's Christian Temperance Union of Indiana.

4. Each councilor and secretary of each county medical society gets a copy of each article.

5. Editors of 275 newspapers and magazines of the state receive copies. Besides these, the articles often are carried in the *Hoosier Health Herald* of the Indiana Tuberculosis Association, and several other health publications of the state, including twelve religious, fraternal and farm journals.

XII. Radio Talks.

Radio talks as follows have been given each week throughout the year on Saturday night over station WFBM of Indianapolis:

The Common Drinking Cup.
Defines Tooth Decay (dental release).
Preparation of Children for School.
How Can You Know?
Lurking Tooth Ills Revealed (dental release).
High Blood Pressure.
Where Do You Sleep?
Competitive Athletics.
Hoosierland's Health Harvest.
Shock Troops Against Disease.
Cold Facts.
Ventilation.
So-Called Cancer Cures.
A Word to Hunters.
Trouble-Making Habits (dental release).
Laxatives and Appendicitis.
A Campaign Against Appendicitis.
The History of Influenza.
The Common Cold.
Holiday Health.
Health Resolutions.
Sinus Trouble.
Smog Sickness.
Carbon Monoxide Gas.
Basketball and Physical Examinations.
Home Safety.
Neuralgia.
Superstitions about Health.
Exercise.
Mumps.
Sport for Health's Sake.
Hot Cereal and Milk.
Your Years and Your Age.
Spring Exercise.
Dental Research in Relation to the Child (dental release).
Spring Tonics.
Spring Cleaning.
Health Days Are Here Again.
Vacations and Typhoid.
Keep Your Eye on the Ball.
Strenuous Week Ends.
Prevent Hay Fever Now.
Cracked Toes.
Causes of Illness.
Safe and Sane Swimming.
July Fourth Injuries.
Hot Tips on Keeping Cool.
Infant Care in Warm Weather.
Chiggers.

XIII. Financial Statement of Bureau.

The expenditures of the Bureau from August 1, 1932, to August 1, 1933, follow:

Clipping service	$73.15
Postage	81.28
Stationery and mimeograph supplies	110.18
Printing	35.50
Traveling expenses of speakers	46.69
Miscellaneous	18.75
Total expense	$365.55

The Bureau was allowed by the Budget Committee $395.00 for the year of 1933. Of this amount the committee has spent $244.68 from January 1 to August 1, 1933, leaving a balance of $150.32 unexpended in the budget for the remainder of 1933.

XIV. Conclusion.

The Bureau of Publicity at this point wishes to call attention to the splendid services which Dr. Miles Porter, Sr., of Fort Wayne, has rendered the profession during his long and active life. The Bureau takes this opportunity to express its appreciation for his service in medical organization work throughout his life and to wish him well.

To Mrs. Edna Hatfield Edmondson, who after many years of service has resigned as executive secretary of the Indiana Congress of Parents and Teachers, the Bureau of Publicity here wishes to express its deep gratitude for the help and cooperation she has given the Bureau since its establishment. Throughout the winter months the articles of the Bureau of Publicity were sent to Mrs. Edmondson's office from where they were distributed to the various local communities of the parents and teachers organization throughout the state. Had not this field been open it is doubtful whether the Bureau could have reached the public as effectively as it has been able to do. The Bureau sincerely regrets to hear that Mrs. Edmondson has resigned her position as executive secretary of the Indiana Congress of Parents and Teachers. It, however, is making arrangements to continue to cooperate with the parents and teachers group in the future along lines which it hopes will prove as effective as in the past.

Respectfully submitted,

William N. Wishard, Chairman.
J. H. Stygall.
E. D. Clark.

COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

I. GENERAL HOSPITAL SITUATION.

The following tabulation sets forth the average percentage of *occupied beds* in the general hospitals of the United States for the years designated.

1929	1930	1931	1932
65.5%	64.7%	64.4%	63.3%

These figures seem significant when contrasted with those for Indiana covering the same period.

1929	1932
53.5%	47.2%

When these percentages are broken up into the classifications as regards the control of the hospitals, the results are as follows:

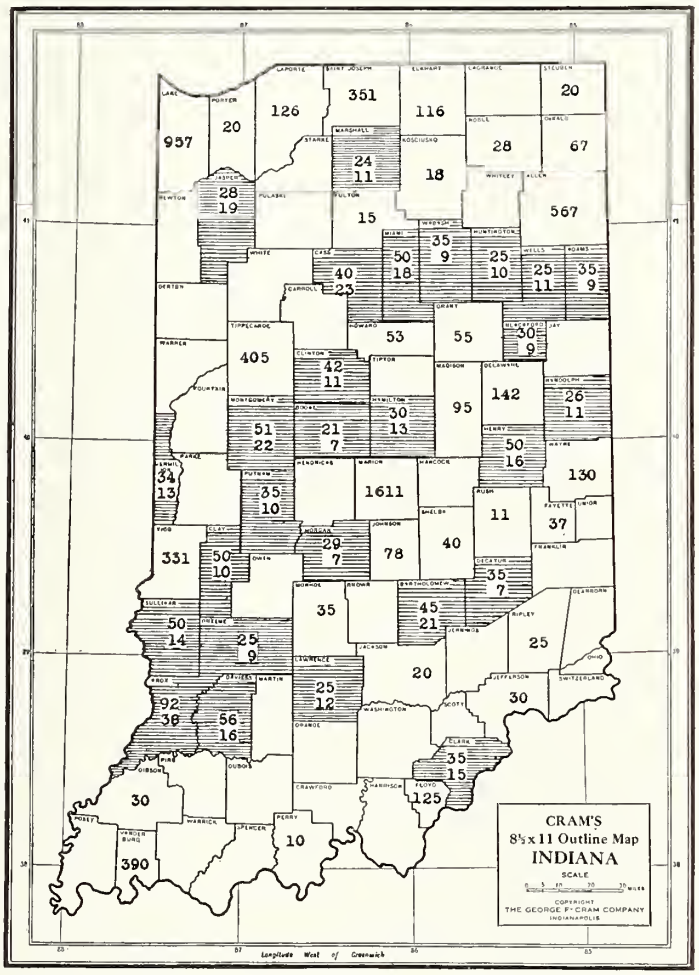
	1929	1932
County	45%	38%
Church	64%	51%
Independent	56%	55%
Individual	75%	45%

Omitting from consideration the institutions of individual control, it is seen that the county hospitals have suffered the greatest decrease in occupied beds. When it is borne in mind that the average bed capacity of the county hospital in Indiana is 37, it is apparent that the 38% of occupied beds brings the number of patients cared for to a painful few.

The accompanying map setting forth the counties having general hospitals of county control is of interest chiefly because it reveals a rather inconsistent development. As an instance we have an example where, within less than thirty miles of a county whose institutions of other than county control supply 331 general hospital beds, five county hospitals are located. These five county hospitals supply an additional 194 beds; and of these beds less than 24% are occupied.

There is a second example where five county hospitals are found within about thirty miles of a medical center supplying 567 beds. Again, we find two county hospitals located in counties of fewer than 14,000 population; and one of these is adjacent to a county with other hospitals supplying 957 beds.

The establishment of county hospitals in Indiana was most active in the years from 1920 to 1928. During this time thirteen hospitals were added and none have been built since the latter date. This might indicate that saturation had been reached; and the occupied bed figures suggest that it may have been exceeded.



The shaded areas are of counties having hospitals of county control. The upper figures in these counties indicate the bed capacity of the hospital and the lower figures the average occupied beds. Figures in the unshaded areas show the number of general hospital beds in the respective counties.

The conclusion seems well supported that the county hospital development has not grown in direct response to actual need for the services they supply. It seems probable that local pride in community interests may have supplied the stimulus. Whatever the causes, the results have been the unequal distribution of a large number of small and, in many instances, inadequately manned and poorly equipped hospitals. This being the situation, much of the medical work developing in the area served by the many referred to, must necessarily go elsewhere for attention.

The county hospital development is not found throughout the United States. California and Indiana are the only states showing a decided tendency in this direction. In California the movement toward the county hospital antedated that in Indiana by a few years; and, it seems they have made a start toward correcting former mistakes. It is noted that California had 49 county hospitals in 1927, while in 1932 the number had shrunk to 34 and with many of these serving more than one county.

The laws of the State of Indiana would permit

each of its 92 counties to issue bonds for the purpose of building both a general hospital and a hospital for the tuberculous. Since it is obviously absurd that all should do so, we are forced to think of larger than county units if we plan to extend to all our population the advantages of these services.

Mr. Paul Fesler, President of the American Hospital Association, speaking before this Association at its last meeting, said: *"I think, not another bed should be provided in a public institution until the private hospital beds are filled."* With certain very minor qualifications in the way of definitions, this statement seems to be subscribed to by all who think a drift toward state medicine should be curbed. On this account the map is made to carry figures in the unshaded areas indicating the number of general hospital beds in the designated counties of other than county control.

It has been said that the hospital is just as much a piece of the doctor's equipment as his scalpel, stethoscope or obstetric forcep. Just how to achieve the end of bigger and better hospitals, serving areas large enough to support them is our problem; and since they are our instruments we should control them. Detailed plans for effecting the changes necessary to bringing about the more nearly ideal conditions hinted are not worked out. It is common knowledge, however, that practically every county hospital in Indiana was erected under the pressure exerted by the local medical profession. This being true it would seem necessary only to direct attention to where our greater interests lie.

A mere map of the state will be of little aid in determining the proper location for these hospitals of larger than county scope. The districts served will not conform to any present political subdivisions. Automobiles over good roads will quickly bring together patient, doctor and hospital; and we surely do not prefer an inefficient instrument at hand for a proper one a bit removed. Distribution of population, transportation possibilities and proximity to essential institution services are the main points to be considered in selecting a location for such hospitals.

From the foregoing facts and opinions your committee feels that the county general hospital presents the most urgent problem of the general hospital situation in our state. It is further the belief of the committee, that if the members of this Association will look at this matter in its larger aspects, a solution of the problem will be found.

There is such widespread approval of the Federal Government's correction of its former mistaken policy in regard to veterans' relief that further comment seems unnecessary. It is, however, the belief of the committee that, in addition to the considerable saving of funds to be realized, the plan will tend to check a very pronounced tendency toward the establishment of a preferred citizenry, for governmental beneficence, on the basis of an absurd distinction.

Approval is also given to the action of Indiana's last legislature in its enactment empowering the judges of Circuit Courts to commit dependent children to local hospitals on the same basis as that used in commitments to Riley Hospital. This arrangement will remove some of the objections to the former plan, on account of the cost of continuous residence at the distant institution for patients requiring intermittent attention; and also for the care of certain of the less complicated conditions which can be treated equally well with facilities near at hand.

II. Group Hospitalization.

Probably no question of medical economics has received more attention in so short a period of time as has group hospitalization in the past few years. As a result of expansion of both government and private hospitals, the withdrawal of support of endowments, and the inability of a large part of the population to pay for hospital services, hospital managers find themselves in such serious financial circumstances that they are ready to try any project which offers hope of relief.

The plan offered to this Committee for consideration is a non-profit co-operative scheme in which all hospitals in a community participate. According to the particular plan submitted to this Committee, the annual subscription rate would be $12.00. This fee would entitle the subscriber to 21 days in the hospital in a room costing $4.50 per day. We understand that additional services, such as x-ray, laboratory and operating room are included. The cost of organization is estimated at $2.00 per subscriber. Based on a population of 40,000, it is estimated that there would be an enrollment of 5,000. Most of the recent plans call for an advisory council from the local medical society as an adjunct to the Board of Trustees of the fund.

The morbidity expectancy is estimated at 12 per cent. This figure is arrived at by a study of the present morbidity statistics. The estimation of what per cent of those insured would demand hospitalization is obviously a difficult task. Such illnesses as tuberculosis, mental disease, and obstetrics are not included, although some of the plans include childbirth 300 days and others a year after enrollment.

The legal status of group hospitalization is established in Indiana. The State Insurance Commission has recently received a ruling from the attorney-general that hospitals furnishing a specific service on a periodic payment plan are not engaging in the insurance business.

As an aid to carrying out the experiment of hospital insurance, a grant of $5,000.00 has been obtained from a large insurance company and

philanthropic foundations have offered the services of their medical economic experts. These aids are being made use of by the Council on Community Relations and Administrative Practice of the American Hospital Association.

The principle of group hospitalization schemes has been approved by the Board of Trustees of the American Hospital Association. This organization has accepted the plan as a means of distributing the costs of medical care and relieving the financial burden incident to illness of those with limited incomes.

It may be said in favor of these schemes that: aside from their organization they are not profit-taking; they distribute the burden of hospital costs among a large number; they provide hospital care for many who would be on charity; they assure a fairly high standard of medical care; they leave the patient in a better position to take care of his physician's fees, and the choice of physician and the amount of professional fees are not affected. It is also claimed that a non-profit co-operative plan would prevent the vending of hospital and eventually professional services by unethical commercial concerns.

Early this year the Bureau of Economics of the American Medical Association made an extensive study and report of hospital insurance schemes. In this report the merits as well as the present and prospective defects of the entire plan were pointed out. Consequently some of the more recently devised plans have attempted to meet the objections made.

The entire adventure appears to be in the experimental stage. The British system has been in operation for a number of years with some degree of success; but some of the defects of the plan have become apparent there. It is already evident that the managers of the schemes are using their power to control hospital management. There, also, the system has worked to the detriment of the medical profession by increasing the work of the hospital staffs without remuneration, and consequently lowering the standard of work done.

In the organization of the plans it is to be expected that some of the hired salesmen will use "pressure" and give subscribers the impression that all medical care is to be provided. If the average person is assured that he is to be cared for in a hospital in case of illness, he will feel less urge to put away any savings for such an emergency. Fees for professional service will be just as difficult, if not more difficult, to collect.

Many of the leaders of our profession have recently pointed out that too many patients are being hospitalized. It is difficult to understand how widespread hospital insurance can be kept from increasing hospitalization, and that is happening already in some places where the plan is being tried. In all the plans the attending physician is the one privileged to decide on the patient's need of hospitalization. It is much easier for most physicians to treat patients in the hospital than at their homes, and at no extra cost most patients would prefer to be treated there, even for minor illnesses. Already subscribers have insisted on, and succeeded in being, hospitalized when all they needed was rest.

Rival schemes are very likely to spring up with competitive practices of lowering payments and giving inferior service. If the plan is successful, it is likely that an attempt will be made to extend it to professional services.

We have no doubt that some satisfactory and equitable plan of hospital insurance will eventually be worked out. In caring for a certain class of people, it will be for the best interests of the profession and hospitals as well as the patients. At present the plan of enrolling groups, such as employes, lodges, unions and professional associations is preferable to enrolling individuals. The cost for organization and administration is, of course, much less for groups than for individuals.

Communities should be on their guard against accepting any hurried ill-advised scheme proposed by an organizer who expects to make an exorbitant profit.

It is the opinion of the Committee on Medical Education and Hospitals of the Indiana State Medical Association that co-operative group hospitalization at the present time is an experiment and should not be recommended.

III. Medical Education in Indiana.

The criticism has been made that Indiana University, by paying its medical faculty salaries, makes it possible for them to engage in unfair competition with the practicing physicians of this state. However this may be in other state universities, it is not true of Indiana.

The very small salaries first paid for laboratory and administrative work to those teachers who were also in private practice before the first hospital of Indiana University was built, when the entire property of the University in Indianapolis, was the old medical building on Senate Avenue, were the same as those paid them today. Their work has been increased greatly by these hospitals; their salaries, not a bit.

With the exception of the full-time residents and a half dozen recent graduates who since the hospitals were opened have given half-time to university work on fellowships, no salary at all is paid for clinical work.

The medical school work of clinical men represents a definite sacrifice on the part of each.

Respectfully submitted,

Paul S. Johnson, M. D., Chairman.
David A. Bickel, M. D.
Charles P. Emerson, M. D.

REPORT OF COMMITTEE ON CIVIC AND INDUSTRIAL RELATIONS

House of Delegates, Indiana State Medical Association:

Gentlemen: Through the efforts of the Committee on Civic and Industrial Relations over the past several years, it appears to our committee that the co-operation between the physician of the State of Indiana and the industrial insurance carriers has greatly improved. Without exception the insurance companies have accepted the decisions of the committee in the arbitration of fees, and in a number of these cases the decisions have not been in their favor.

During the past year the committee has endeavored to collect material to present to the State Association regarding the practice of a few members of the profession of bidding for industrial work. Following a rather extensive inquiry, addressed to the insurance companies operating in the State of Indiana, we found only a few which imposed their own fee schedule on their physicians. The reason that the industrial work in the State of Indiana is being done below the established fee basis in many places is often the fault of the individual physician, rather than of the insurance carriers. When we can come to a better understanding among ourselves and everyone abide by an established fee, this condition will be corrected. As long as one member of the State Association will bid against another member for industrial work, the insurance companies will take advantage of this situation. The committee hoped to have established a fair fee schedule to submit to the House of Delegates at the annual meeting this year, but the material is not complete.

Another problem that has confronted the committee during the past year is that of figuring out a method of determining disabilities other than on the percentage as a whole. The method now recognized by the Indiana Industrial Board is thought to be unfair by a great many men, because in settling any dispute there is such a wide variation in the individual physician's estimate of disability. The problem of determining a better method for establishing the percentage of disability is being worked on, but the committee has, as yet, no final report ready.

The committee recommends that a more intense effort be made through the county societies and the individual members of the State Association to adhere to the county fee schedule in doing industrial work and to avoid unfair competition by the reduction of fees.

Respectfully submitted,

W. W. WASHBURN, M. D., Chairman.
W. C. MOORE, M.D.

REPORT OF REGISTRATION COMMITTEE

House of Delegates, Indiana State Medical Association:

Gentlemen: A register of licensed practitioners is a public obligation of every state board. With the best of state boards, after the passing of a number of years, the licentiate is frequently lost sight of, making it difficult to determine if he is still active in ethical practice, deceased, or removed from the state.

What are the benefits to be derived from annual registration?

First: Periodic registration has been referred to as the salvation of reputable medicine.

Second: It certainly exercises a distinct leverage on the unlicensed practitioner.

Third: It furnishes increased funds for the use of the Medical Board.

Fourth: It removes the burden of prosecution from the local medical society.

What are the objections?

There is only one if it may be called such. It would seem that it places a burden upon a certain class, namely the medical profession, which should be borne by all the state since the people of the state are in a large measure benefited.

Replies to questionnaire:

Through the courtesy of Dr. Olin West, secretary of the American Medical Association, your committee was given a list of those states having a registration law.

There are eighteen states having such a law.

To the secretary of the state medical association in each of the states a letter was addressed which read as follows:

How long has your state had a registration law?

What is the fee?

What is the attitude of the medical profession in your state toward such a law?

Replies were had from eleven states, as follows:

Florida, six years; $1.00; not altogether sympathetic.

Oregon, six years; $1.00; favorable.

Pennsylvania, four years; $1.00; basically unfair.

Nevada, one year; $2.00; no complaints.

California, three years; $1.00; heartily approved.

North Dakota, two years; $5.00; approved.

Minnesota, five years; $2.00; heartily endorsed.

Nebraska, five years; $1.00; not altogether sympathetic.

New York, five years; $2.00; attitude not given.

Colorado, two years; $2.00; not unified.

Louisiana, four years; $2.00; attitude not given.

Copies of the law were received from the following states and a part of this report is based upon the information contained in the pamphlets: Florida, New York, Louisiana, Minnesota, Oregon.

After due consideration your committee did not

think that it was its duty to attempt to formulate a law but simply to bring the facts to you for your guidance.

Conclusions:

1. Annual registration of physicians should occur to keep an up-to-date record of all licensed to practice.
2. Annual registration aids in preventing the use of licenses by persons not entitled to them.
3. Annual registration makes it possible to know the number of registered medical doctors in the state.
4. Where cults are licensed, complete annual registration of all licensed to practice should be had.
5. An annual directory should be published of all licensed to practice the forms of healing permitted in the state.
6. Directories should be furnished free to all licentiates, to local law enforcement officers, and to various interested agencies, such as insurance companies, etc.
7. The registration fee should be available for the use of the board and any funds remaining at the end of the year should not be turned over to the general fund.
8. The amount of the fee should be sufficient but not more than necessary to supplement other funds available to the board in the performance of its duties including supervision of licentiates and vigorous prosecution of the unlicensed.
9. Annual registration should be effected with minimum inconvenience to licentiates.

Respectfully submitted,

E. Van Reed, M. D., Chairman.
Chester A. Stayton, M. D.
E. H. Brubaker, M. D.

REPORT OF COMMITTEE ON NECROLOGY

House of Delegates, Indiana State Medical Association:

Gentlemen: Life minus its aesthetic values would be barren indeed. Though we may often forget the fact, beauty is as essential for our well-being and happiness as are shelter, clothing and food. Fortunately, beauty appears in many forms —in painting, in literature, in music, in sculpture and, no less, in the accuracy and delicacy of technique and expert skill that is demonstrated many hundreds of times in the hospitals by the medical men and women of the country, and, moreover, in a thousand glories of Nature. Not only are we moved at twilight by the rose colors of the western sky, or by the sparkling stars that sprinkle the vault of heaven at night, but deep in our beings there is a love for growing things, for living objects that in graceful forms and lovely colors and with sweet odors spring miraculously from the warm bosom of the soil. Even a single blossom, growing in a clay pot on a window sill, has opened to a weary soul a glimpse of heaven.

Then, likewise, has the skillful hand and trained mind of the careful medical man brought new life and hope and happiness into the families and homes of many thousands of the sick, suffering and depressed in all climes, countries and nations. Thus the beauty of the efficiency of the profession has been the crowning glory of millions of lives, young and old, the infant and the aged, to all colors and creeds, bringing joy in renewed health to the very window sills of the sick as the blossom brings heaven from the pot of clay.

This report dates from the first of August, 1932, and includes the number of our members who have gone on to "Specialties Unseen by the Eyes of the World" up to the first of August, 1933. The committee regrets to have to account in this list the greatest number since we have been attempting this work. One hundred and fifteen good, noble physicians answered "The Last Call" in Indiana during the fiscal year. This is an increase of 22 as compared with 93 of last year. This number has been slightly influenced by the fact that there are two suicides and three accidents as the causes of death in the large number.

The committee is also prompted to state—selfishly perhaps—that among this number 5 were our classmates. Two of these succumbed in their homes in Indiana and the other three died while on various missions in foreign lands.

The oldest member of the group was Dr. Thomas Hamilton Payne, of Friendship, Indiana, who died at the age of 89 years and three months. The youngest was Dr. Jean R. La Vanchy, of Carthage, Indiana, who died in early youth, comparatively, aged twenty-five years.

February of 1933 led the months in number, there being thirteen deaths in this month. Next came January and May of 1933 with twelve each; July of 1933 had eleven; November of 1932 had ten; August of 1932 and March of 1933 each had nine; September, October and December of 1932 each had ten; while April of 1933 had nine.

Two of the number were between twenty and thirty years of age; one was between thirty and forty; twelve were in the forty to fifty decade; nineteen between fifty and sixty; the greatest number, twenty-six, between sixty and seventy; a close second was the twenty-five between seventy and eighty; and a remarkably large number, eleven, between eighty and ninety. The exact age of nineteen of the deceased could not be ascertained by the committee. The combined ages of those thus accounted was 7,195 years, or an average age of 62.5 years.

The causes of death were as follows: Heart disease led the list with twenty-nine victims; pneumonia came second with twenty-one; gall bladder disease, with and without stones, and with and without operation, claimed thirteen; diabetes, twelve; Bright's disease, ten; cancer of stomach,

six; influenza, five; cancer of liver, three; cancer of rectum, two; suicide, two; auto accidents, two; and burning, one. The causes of death in the remaining nine physicians were unobtainable.

Twenty-three graduated from the Medical College of Indiana; twenty from the Kentucky School of Medicine; five from Western Reserve; four from Jefferson; seven from Rush; three from Cincinnati College of Medicine; one from Kansas City Medical College; two from Hahnemann; three from Central College of P. & S. of Indianapolis; two from University of Virginia; one from Pulte of Cincinnati; two from Physio-Medical of Indianapolis; one from Northwestern University Women's Medical of Chicago; one from Louisville Homeopathic School; two from Eclectic of Cincinnati; one from Laura Memorial of Cincinnati for Women; two from Fort Wayne; two from General Medical of Chicago; two from Chicago Homeopathic; four from University of Illinois; ten from Medical College of Ohio; one from Starling; one from Bellevue; one from Baltimore Medical; two from Northwestern of Chicago; one from University of Tennessee; one from Meharry of Nashville; one from Toledo Medical; one from University of Colorado and one from St. Louis University. The school of preference of the remaining seven doctors could not be learned. There were four women physicians among the number. Also included were two Eclectics, three Homeopaths, and two Physio-Medicals.

The average time spent in practice by the number that could be accurately tabulated was 27 years and 6 months. The total number of years spent by these men in caring for the sick of Indiana in their respective locations was 3,162 years in even count. More than one third of this work and service was done gratuitously, with a very conservative estimate. It is very likely that no other class of men and women of any profession in all the world contributes to the welfare of the people as a whole as does the medical profession. And certainly no class is less sincerely appreciated and compensated. Yet, we as physicians, do have occasionally a bright spot of cheer in the form of an appreciative, sincere, honest patient who, because of the priceless joy he has received at the hands and from the mind of the doctor, in the form of renewed health, happiness and prosperity, is delighted to impart to his best friend on earth, his physician, the deep sincerity of his love and devoted friendship. Below is such an expression from one of this type of patients and friends. These fitting words were written to a doctor who had done just his regular day's duty, but who happened to be deeply appreciated.

MY FRIEND

"I could sail the waters of all the world,
Bitter and wild and blue,
And never I'd find a friend to love
Like the friend I've found in you.
I could walk down all the roads of the world,
And knock on the doors forever,
And never I'd find a friend like you,
NEVER—NEVER—NEVER!"

—J. P. McEvoy.

Respectfully submitted,
George G. Richardson, M. D., Chairman.

REPORT OF COMMITTEE ON POST-GRADUATE STUDY

House of Delegates, Indiana State Medical Association:

Gentlemen: The second annual Post-graduate Meeting of the State Association was held this year in the Sixth District at Richmond, Indiana. The meeting was well attended with the larger percentage of those attenting coming from either Richmond or the adjacent counties.

The type of program given was of a practical nature and there is ample evidence that such programs are regarded as being of a distinct value to those who attend. After two years of trial it would seem that a program of this type is of distinct value to the Association and is capable of development into a permanent asset. Attention is called to the fact that the question of financing this type of program offers some objection to it. The efforts of the committee were directed towards getting as speakers men with teaching ability and experience. These men require that their expenses be paid, so that unless the registration is large or registration fee increased, there will be difficulty in the financing of a meeting of this type. An outstanding observation of the meetings for the last two years shows conclusively that the type of speaker for these meetings is of extreme importance in the value of the meeting. The speakers must be men, in the main, with experience as teachers in their various fields, who understand pedagogical technique, and who are sufficiently familiar with their subjects to present them in a broad and fundamental manner.

Respectfully submitted,
Murray N. Hadley, M. D., Chairman.
Robert Moore, M. D.
G. A. Collett, M. D.
J. H. Hare, M. D.
W. L. Portteus, M. D.
W. D. Gatch, M. D.

REPORT OF COMMITTEE ON STUDY OF HEALTH INSURANCE

House of Delegates, Indiana State Medical Association:

Gentlemen: As chairman of the Committee on Study of Health Insurance, about all that can be reported is that after the committee meeting in Indianapolis and our request for a letter advising every county to make a serious study of present economic conditions by holding a special meeting

in every society this year, the executive secretary has reported almost universal response to our suggestion. Medical economics meetings were held by the following county societies: Clinton, Hancock, Delaware-Blackford, Montgomery, Hamilton, Owen, Wayne-Union, Grant, Fountain-Warren, Floyd, Bartholomew, Lawrence, St. Joseph, Porter, and Marshall.

The medical profession at this time should not, in our opinion, promote any radical efforts to change present conditions but should be prepared to meet and handle the various problems as they arise. No one plan could be expected to meet conditions in all parts of the state, and so the most good our committee can hope to accomplish is through the co-operation of the county societies as units discussing and studying their own problems in a manner to solve them to the best interests of both the community and the profession.

Respectfully submitted,

M. A. AUSTIN, M. D., Chairman.
WALTER KELLY, M. D.
J. T. OLIPHANT, M. D.

REPORT OF DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

The report for delegates, prepared by Dr. R. L. Sensenich, of South Bend, delegate to the Milwaukee session of the American Medical Association, was published on page 339 in the July, 1933, issue of THE JOURNAL. Notes from the session were prepared by the executive secretary, Mr. Hendricks, and published on page 341 in the same issue.

REPORT OF COMMITTEE ON VETERANS' HOSPITALIZATION

House of Delegates, Indiana State Medical Association:

Gentlemen: Your Committee on Veterans' Hospitalization has had nothing to come before it during the current year. By the action of the last session of the Congress of the United States and orders promulgated by the President, the hospitization of veterans with non-service connected disabilities has been done away with except in the case of those whose disabilities are permanent and total. These are largely mental cases and cases of tuberculosis and your committee feels, and believes that all will concur, that these are just charges of the federal government.

If the present status of affairs is continued, the work of this committee is over. It is possible, however, that this condition may not be permanent and it might be advisable for the committee to be continued for that reason.

Respectfully submitted,

C. C. BASSETT, M. D., Chairman.
F. S. CROCKETT, M. D.
I. M. CASEBEER, M. D.

REPORT OF COMMITTEE ON BUSINESS INSTRUCTIONAL COURSE

House of Delegates, Indiana State Medical Association:

Gentlemen:

Directly following the appointment of the members of this Committee, this Committee met with the Dean of the Indiana University School of Medicine. At this meeting, the Committee was pleased to learn that the University Council was ready to approve a business instructional course for senior medical students which was already tentatively planned by the Dean of the Medical School and by those interested, and were awaiting the approval of their plans and any further recommendations by the Committee on Instructional Course of the Indiana State Medical Association.

The Course:

Definite recommendations made by this Committee and the Dean of the Medical School were approved by the University Council. The course given was as follows:

February 1—General Principles of Ethics—Mr. Daniel S. Robinson, Bloomington.

February 8—Principles of Medical Ethics—Dr. J. M. Barry, Indianapolis.

February 15—Work and Ideals of Organized Medicine—Dr. J. H. Weinstein, Terre Haute.

February 22—Newer Forms of Medical Practice—Dr. Olin West, Chicago.

March 1—Duties of the Doctors in Safeguarding Public Health—Dr. Thurman B. Rice, Indianapolis.

March 8—Conduct of Consultations—Dr. William N. Wishard, Sr., Indianapolis.

March 15—Prognosis—Dr. J. Oscar Ritchey, Indianapolis.

March 22—Code of Medical Ethics—Dr. W. D. Gatch, Indianapolis.

March 29—Problems of the Young Physician—Dr. Cyrus Clark, Indianapolis.

April 5—Saving and Safe Investment—Mr. Evans Woollen, Jr., Indianapolis.

April 12—The Mathematics of Life Insurance—Mr. Charles Beckett, Indianapolis.

April 19—What Price Glory—Dr. B. D. Myers, Bloomington.

April 26—The Office Equipment of the Doctor—Dr. Carl McCaskey, Indianapolis.

May 3—The Work of the Indiana State Board of Medical Registration and Examination—Dr. William R. Davidson, Evansville.

Reactions:

a. *The senior medical students* received this course with utmost interest and appreciation. The personal and practical features of this course appealed to the students as most helpful.

b. *The members of the Association* and the medical profession of Indianapolis were invited to the course. The attendance was small due to inadequate publicity. Those who did attend found the course most practical and helpful. They found it filled a much needed essential in medical train-

ing, and were especially proud to know that the Indiana University School of Medicine was included among the pioneers in adequately meeting this need and advancing its general adoption by the medical schools of the world.

c. It has been brought to the attention of the Committee that the *University authorities* consider this course to be an innovation in medical teaching. They found that the interest in the course was very great. Dr. William Lowe Bryan, President of Indiana University, praised this course. He went to Indianapolis and gave one of the lectures. The University authorities are highly pleased with the fact that our Association has been successful in having the American Medical Association recommend such a course to all medical schools. They also feel that this further aids Indiana University as a leader in medical teaching. Further, the University authorities felt this course was so highly successful that two of the lectures were repeated and included in the postgraduate course which was given very recently.

Recommendations:

1. Regarding the future of the business instructional course:

a. Better publicity through Indiana State Medical Association JOURNAL, the lay press, University Press and University catalogues.

b. Certain minor revisions of the course, which will be found necessary from time to time, during the semester.

2. *Regarding Committee:*

a. That the Indiana State Medical Association make the Committee on Business Instructional Course a permanent committee. This Committee to act as a consulting committee with the Dean of the Indiana University School of Medicine, and recommend such changes in the course which the members of the Association from time to time find necessary and advisable.

b. That the Indiana State Medical Association, through this Committee, study the instructional course of the Indiana University School of Nursing with the express purpose of planning with the University Council and Dean of School of Nursing to make available adequate instruction for nurses in the various branches of endeavors allied to medicine which are now mostly done by laymen; namely, medical social service, office assistants for physicians, x-ray technicians, laboratory technicians, etc. Your Committee feels that these additional instructional courses will materially reduce to a minimum the large number of lay individuals working in the field of medicine, and will more adequately assist the medical profession in furnishing the public properly trained assistants in the closely allied branches of endeavor.

Respectfully submitted,

GEORGE J. GEISLER, M. D., Chairman.
C. J. CLARK, M. D.
G. D. SCOTT, M. D.

REPORT OF COMMITTEE ON STUDY OF HIGH SCHOOL ATHLETICS

House of Delegates, Indiana State Medical Journal:

Gentlemen:

This committee is accumulating all data which will be helpful in determining the best ways to safeguard the health of those who participate in high school athletics.

Numerous examples have come to our attention where boys have played strenuously for a number of years and then have become seriously ill with tuberculosis, kidney or heart disease, or some other ailment. Of course, other individuals become affected with these same diseases and the fact that these things develop after participation in athletics is not sufficient to cause us to blame athletics entirely for their occurrence. This committee feels that a study of these cases will be helpful in formulating a better plan of supervision of the members on the various high school teams.

Letters have been written to approximately thirty physicians who have been closely associated with some of the representative basketball squads. These were chosen at random, in order to get opinions from all parts of the state. This committee urgently requests that doctors having special knowledge of illnesses in boys who have been active in athletics and especially of those cases which might serve to avoid similar occurrences in the future, communicate such information to this committee.

Under the present system, all boys who participate in track, basketball, and football are certified by their parents and by a member of the medical profession. This certificate requires sufficient examination to rule out the unfit if it is carefully done. A few instances have come to our attention in which this examination was not well done and the boy was certified for participation when he should not have been. This is a relatively rare occurrence and it seems that the present system is a good one in so far as it weeds out the unfit. However, it seems that a somewhat closer supervision after the initial certification would be advantageous. Individuals and sometimes an entire squad may be affected during the playing season by epidemics of acute disease especially respiratory diseases and tonsillitis, and these things occur often during the tournament weeks. On account of the intense community feeling, it may be very difficult to keep a regular player, particularly if he is one of the stars, out of the game, even though he is physically unfit. This point deserves some publicity since it will help the coach and particularly the doctor attending the squad, to handle the situation.

The point of most importance, it seems to us, is not how much a perfectly well and sound boy can play, but to determine at all times, whether he is physically fit to play at all. To allow boys to play with fever or while convalescing from these acute diseases will often be detrimental to future health.

In this connection it would seem wise to fix the responsibility of who shall say whether a given participant is fit or unfit. We know that at times a doctor has advised a boy not to play and then the boy himself, or influenced by friends or family or rarely by his coach, has consulted other physicians until he found one willing to say that he could play. This should be prevented.

The following resolution was submitted from the Indiana Tuberculosis Association to the headquarters office of the Indiana State Medical Association and was referred to this committee.

"Resolved, That in the interest of sound public health and to protect our growing youth that tuberculin skin test, to be followed wherever possible by x-ray examination of the positive reactors be included as a part of the examination to determine fitness for participation in the more strenuous forms of athletic competition among our grade, high school, and college students, and be it further

Resolved, That those children showing positive x-ray findings be excluded from such competition, while the exclusion of markedly positive reactors to the skin test, either where the x-ray findings are negative or where x-rays are unavailable, be a matter of judgment for the medical examiner and family physician."

W. H. Mytinger, M. D., Lafayette,
E. M. Amos, M. D., Indianapolis,
J. V. Pace, M. D., Rockville,
Committee.

This resolution is included in our report because it takes such a sound position. The judgment of competent physicians in these special cases should be more generally satisfactory than hard and fast rules particularly when an interpretative test such as the skin test is to be made the basis for exclusion from athletic competition.

These matters are of real importance. We have details of three recent tragic examples. One young man played four years high school and four years college basketball. He now has active tuberculosis with positive sputum, hemorrhages, and a cavity. Another died from a very acute tuberculosis after four years of active high school basketball. Another died with advanced nephritis with high blood creatinine and non-protein nitrogen after four years of activity in high school sports. While these same diseases occur more often in young men who have not participated in any form of athletics our attention is focused more intently upon the athletes because of the publicity these cases receive. It should be possible to protect the physically fit and athletically capable boys from these fatal outcomes by closer supervision. The fact that there is a great variation in the medical supervision and control of participants in different communities, and the fact that there is in some quarters a tendency to consider strong and athletically active boys practically immune to serious disease is sufficient cause to interest the medical profession in the study of these problems.

Respectfully submitted,

W. D. LITTLE, M. D., Chairman.
GEORGE HOLLAND, M. D.
H. C. WADSWORTH, M. D.

REPORT OF THE PUBLIC RELATIONS COMMITTEE

House of Delegates, Indiana State Medical Association:

Gentlemen: The following were referred to this committee for investigation: First, the payment of three ($3.00) dollars to the County Clerk for filing and two ($2.00) dollars to the physicians for examination and referring cases to the Riley Hospital for Children at Indianapolis.

So far as we are able to learn there is no state law permitting these charges. Some counties (Vigo County is one) pay the clerk three ($3.00) dollars and the physicians five ($5.00) dollars for this service which of course does not concern this association. Should there be a state law permitting these charges, we sincerely think it should be repealed.

Second, there seems to be a desire to eliminate all private rooms at the Coleman and Long hospitals.

After talking with quite a number of physicians, both in the University and out, we find that there is quite a great deal to be said both for and against this proposition. We then took up the legal side of the matter and I have asked the attorney for the Association, Mr. Albert Stump, for an opinion as to whether or not it was possible to eliminate full pay and part pay cases from the Coleman and Long hospitals which is here given:

COPY

August 3, 1933.

Dr. William P. Garshwiler,
Hume Mansur Bldg.,
Indianapolis.

My dear Dr. Garshwiler:

Upon your request we have investigated the facts in regard to the establishment of the William H. Coleman Hospital for Women and the Robert W. Long Hospital, and the legal implications developing from such facts with reference to accepting pay patients, and we submit this as our opinion upon the situation existing as to both hospitals.

The William H. Coleman Hospital was established by an act of the Legislature in 1927, accepting donation of property valued at $250,000 from William H. Coleman for that purpose. Mr. Coleman, in making the gift, made a proposal to the Trustees of Indiana University and the gift was accepted in accordance with the terms of that proposal. The act of the Legislature accepting the gift recites the proposal, and that section containing the proposal and the acceptance thereof is Section 1 of Chapter 213, page 607, of the Acts of 1927, and reads as follows:

"Be it enacted by the General Assembly of the State of Indiana, That the gift of William H. Coleman for the establishment and maintenance of a hospital in Marion county, Indiana, and to provide clinical facilities for students in connec-

tion with the Indiana university school of medicine as contained in the following proposal:

"To the trustees of Indiana university:

"I propose to give for the benefit of Indiana university school of medicine at Indianapolis, real estate located at the corner of Illinois and Vermont streets in the city of Indianapolis, valued at $175,000, which will be under ninety-nine years' lease bearing five per cent interest on that amount, with an increased rental each five years for three periods. I, also, will give property and securities to the amount of $75,000 additional, making $250,000 in all, for the purpose of building on the state's property at Indianapolis (near the Robert W. Long hospital), and to be used chiefly for lying-in patients and a smaller number of gynecological cases; provided that the trustees shall have authority, when all beds are not occupied for the above purposes, to use them for other classes of female cases according to their best judgment.

"The proposed hospital is to be known as William H. Coleman hospital for women, and is supported by the state of Indiana and to receive for care and treatment both patients who are not able to pay and patients who are able to pay part or all of the expense of their care at such an institution.

"The property included in this proposition will be subject to the taxes of 1924 and the income on the gift is to begin April 1, 1925.

"The proposed hospital building is to be erected in 1925 if possible.

"(Signed) William H. Coleman.

"Indianapolis, Indiana, December 16, 1924.

"be and the same are hereby accepted by the State of Indiana for uses and purposes therein named."

Special attention is invited to the second paragraph of the proposal, containing the provision that the hospital is to be supported by the State of Indiana and to receive for care and treatment "both patients who are not able to pay and patients who are able to pay part or all of the expense of their care at such an institution."

Section 2 of the same act reads as follows:

"That the trustees of Indiana university be and they are hereby authorized and empowered to accept the control and management of said donations, and are hereby charged with the administration of the affairs of said hospital in accordance with the terms and conditions imposed by the donor of said gifts."

Section 3 contains the following provision:

"The faith of the State of Indiana is hereby pledged to carry out the objects for which said donations are made, as contained in the proposal of said donor, and this act shall not be repealed or so amended as to change the terms and conditions under which said donations are made."

In completing the donation real estate was transferred by Mr. Coleman to the State of Indiana and the Board of Trustees were authorized to sell the real estate. This has been done.

In view of the facts above stated, the Coleman Hospital is under obligation to receive patients who are able to pay part or all of the expense of their care. This obligation cannot be changed by an act of the Legislature, for it now rests upon contract rather than upon any matter of administrative discretion in the handling of this state institution.

The situation in regard to the Long Hospital is practically identical with that in regard to the Coleman Hospital. The Long Hospital was established under Chapter 8, of the Acts of 1911, page 15. The first section of the act establishing the Long Hospital contains the proposal from Robert W. Long and Clara J. Long to make a donation for the purpose of establishing a hospital to be known as the Robert W. Long Hospital of Indiana University. That proposal contains a statement of the purposes to be accomplished by the donation, and the first of those purposes is stated as follows:

"First. By making it possible for worthy persons of limited means from all parts of Indiana to secure hsopital advantages and the services of the best physicians in connection therewith, such as can now be had only by those residing in the cities where public hospitals are established."

In addition to this purpose is the purpose expressed of providing clinical facilities for students of medicine, and the proposal contains this statement of the donors:

"We desire, therefore, that the hospital established by us shall be equipped and conducted in such a way as to be as beneficial as possible to medical science and to medical education."

The means by which the purposes of the gift were to be accomplished were kept somewhat in the control of Dr. Long by one of the conditions of the gift, which was, "That said Doctor Robert W. Long shall be, during the remainder of his lifetime, chairman of the committee appointed by the trustees of Indiana university, to build and manage said hospital."

The conduct of the hospital during the lifetime of Dr. Long while he was chairman of the committee will clarify any question of construction of the language of the proposal. The state, having conducted the hospital in accordance with regulations made while he was chairman, would, by that act, be deemed to have put a construction upon the terms of the gift conformable to the regulations under which it was operated, and this would have somewhat the sanction of an executive construction of the meaning of the proposal. This proposal was accepted, and in Section 8, page 20, of the Acts of 1911, the faith of the state is pledged to carry out the objects for which the donation was made, and that section, in part, reads as follows:

"This act shall not be repealed or so amended as to change the terms and conditions under which said donations were made."

Under the circumstances then by which the state came into the ownership of the property covered by the donation the state is bound by the obligations of a contract with reference to the conduct of the Robert W. Long Hospital. This could not be changed by an act of the legislature, for the conduct of the hospital is not left entirely upon the basis of administrative discretion in the management of it as a state institution.

We are therefore of the opinion that neither the Coleman nor the Long Hospital can be operated upon the basis of admitting solely non-paying patients, and that to do so would not be in complete conformity to the terms of the contract which the state made in accepting the donations upon which these two hospitals were originally founded.

Sincerely yours,

ALBERT STUMP.

We hope this opinion will convince everyone, whatever his belief, that the trustees are acting in accordance with the terms of the bequest and cannot legally do otherwise than to maintain private rooms for full and part pay cases.

Sincerely yours,

W. P. GARSHWILER, M. D., Chairman,
J. B. ROGERS, M. D.,
H. L. MURDOCK, M. D.

REPORT OF COMMITTEE ON LYE BURNS IN CHILDREN

House of Delegates, Indiana State Medical Association:

In the effort to present an educational campaign for the public in order to prevent needless suffering on the part of little children from the corrosive action of commercial lye preparations, your committee begs leave to make the following report:

1. Your committee has prepared a release for the lay public through the Bureau of Publicity of the Indiana State Medical Association, presenting the dangers of commercial lye preparations.
2. Your committee endorses the model law as drawn up by the Committee on Lye Legislation of the American Medical Association.
3. Your committee recommends to the Bureau of Publicity that an appropriation of one hundred fifty dollars be made for printing an educational pamphlet for lay consumption, to be distributed through the various Parent-Teachers' or similar organizations.

Respectfully submitted,

EUGENE L. BULSON, M. D., Chairman.
MATTHEW WINTERS, M. D.
REUBEN A. CRAIG, M. D.

REPORT OF COMMITTEE ON SPECIAL MEDICAL DEFENSE FUND

House of Delegates, Indiana State Medical Association:

Gentlemen: The Committee of Special Medical Defense Fund begs leave to submit the following report to the House of Delegates:

That after due consideration, Dr. S. P. Hoffmann's amendment to the amendment to Section Four, introduced by the Executive Committee, is hereby favorably reported out of committee and we recommend its adoption by the House of Delegates.

We furthermore recommend the appointment of a committee of six (6), of which the attorney for the Indiana State Medical Association shall serve in an ex-officio capacity, and the other five (5) members to be appointed from the membership of the House of Delegates, to study malpractice insurance that is now available to the membership of the Indiana State Medical Association. Said committee to be appointed by the president of the Indiana State Medical Association.

This committee to be authorized to invite and meet with representatives of the different commercial companies to learn the different types of malpractice defense protection that they have to offer.

This committee shall, at the next annual meeting of the House of Delegates, give a report in full on information received from said survey.

That said committee be also authorized to obtain all available data and information that might pertain to the Indiana State Medical Association carrying the malpractice protection of its members and the feasibility of not only defending, but assuming full liability for judgment in said cases and to study plans of operation of such a plan.

The committee hereby wishes to pay tribute and extend our thanks to the treasurer of the State Association, Dr. A. F. Weyerbacher, as well as the executive secretary, for the excellent compilation of the history of the Medical Defense Fund of the Indiana State Medical Association.

Respectfully submitted,

S. P. HOFFMANN, M. D., Chairman.
WILLIAM DOEPPERS, M. D.
G. S. WHITE, M. D.

REPORT OF SPECIAL COMMITTEE ON MEDICAL CARE OF THE INDIGENT

House of Delegates, Indiana State Medical Association:

In carrying on the study of the medical care of the indigent in the State of Indiana during the past year, this committee has specifically striven to accomplish three things. First, to ascertain as exactly as possible the details of various plans now in operation in different parts of the state; second, because each of these plans has proved

unsatisfactory from one standpoint or another, to discover, if possible, the causes of dissatisfaction; and third, to formulate certain definite criteria with which we believe any future plan must measure up, if it is to meet with any greater success than previous plans have attained.

Without going into great detail concerning the various plans which have been and are being followed, we find that they fall, naturally, into three principal groups.

Plan One: In which the Trustee or Board of County Commissioners contract with one or two physicians on a salary basis, for all the charity medical work in the community. *Plan Two:* In which the Trustee or Commissioners contract with the local or County Medical Society for a set fee per month, the work being done by the society members in rotation as they are called upon, and the fees being paid into the treasury of the society. *Plan Three:* This calls for an agreement or contract between the Trustee or the Commissioners and the local or County Medical Society, setting forth a definite schedule of reduced fees which obtain for all work done by members of the contracting group, an individual statement being rendered for each case. This plan further calls for a reviewing or auditing board whose duty it is to check all charges made in questionable cases.

The glaring faults of *Plan One,* which fails, usually, to provide anything like good medical care, which throws the great bulk of the work on the unremunerated members of the profession, thereby contributing largely to ill-feeling and dissension among professional brethren in a community, have been so frequently cussed and discussed by numerous investigators from our ranks that I think they need no enlargement here.

Plan Two presents two serious drawbacks in that the contract price is invariably so far below any reasonable evaluation of the services rendered that it is with difficulty that member physicians are kept "sold" on the desirability of the plan. The second serious objection is the large amount of unnecessary calls and office work which it entails. This arises from the fact that the Trustee after signing such a contract, feels himself very largely relieved of any necessity for investigating applicants for medical service, and says, in fact, "Come one, come all," so that the appalling abuse of the privilege of free medical service which almost inevitably arises under this plan is hardly to be wondered at. This constitutes, unquestionably, the most serious objection to this plan from the standpoint of the physician, and after a dozen or so night calls to see patients who have been ailing for weeks or months, or who are perfectly able to come to the office, it is small wonder that the doctor's enthusiasm for such a plan dwindles to the vanishing point.

That no satisfactory solution to these objections has been arrived at is regrettable, for this plan does, unquestionably, tend to augment cohesion among the members of the medical group. It distributes the load equally over the entire profession in a community, permits of free consultation among members on difficult cases, and gives the society a source of income which makes for more profitable scientific group activities.

Plan Three, while perhaps the most difficult to set in operation, seems, in the final analysis, to offer the most promise as an eventual solution to the problem. This plan premises an agreement between the contracting parties which assures the following points:

(1) That all applicants for medical service will be carefully investigated and the need for such service definitely ascertained before any extensive services are rendered.

(2) That medical service rendered under the agreement will be the minimum consistent with good medical and surgical judgment.

(3) Establishment of a fee schedule representing approximately 50 per cent of regular fees for office and house visits and from 15 per cent to 20 per cent of the regular fees for surgery and obstetrics.

(4) Provision for the creation of an auditing or reviewing board whose duty it is to investigate all charges made by physicians and to strike out from the statements submitted all unnecessary or exhorbitant charges.

(5) Provision for some plan of rotation of service among the physicians subscribing to the agreement, so that no discrimination or unequal division of work will occur.

Plan Three will be recognized by readers of THE JOURNAL as identical with the one now in operation in several counties. The measure of success which attends this can be accurately judged only after trial over a considerably longer time than it has had to date, and this will depend largely upon the care with which the preliminary investigation is carried out, and the wise use of the power vested in the adjudication or auditing committees. In the opinion of your committee, it is open to fewer serious objections than any other so far devised, yet is flexible enough to allow minor variation in the details of organization, so that it might be readily adapted to practically any community in the state. It can be made to utilize the facilities of dispensaries or clinics where these seem advisable; co-operation with social service groups may be carried out in the larger centers where the matter of investigation can best be accomplished by these agencies; and by collecting all fees due through the medical society, utilization of these funds so obtained may be managed so that the society can obtain the finances necessary for its continued existence, and still leave adequate recompense to individual members for the services they have rendered.

This committee wishes to recommend the agreement form contained in this report as *Plan Three*

as offering the most satisfactory solution for the problem of caring for the indigent sick in Indiana.

Respectfully submitted,
J. M. FLEMING, M. D., Chairman.
A. C. YODER, M. D.
SAMUEL KENNEDY, M. D.

REPORT OF SPECIAL COMMITTEE FOR THE STUDY OF PUERPERAL MORTALITY

House of Delegates, Indiana State Medical Association:

Gentlemen: The Special Committee for the Study of Puerperal Mortality submits the following:

a. This committee has nothing concrete to offer because certain information which we hoped to obtain through a questionnaire only reached the first stage.

b. After conferring with others than the committee there was considerable doubt in our minds as to how much was desirable in a study of this kind.

The committee did ascertain that where such a study has been undertaken the questionnaire method is the most desirable because the physician having the death is able to throw great light on this particular death. This refers to the economic condition of the patient, whether or not hospitalization could be had, co-operability, etc. The following conclusions were reached:

a. The information contained in the death certificate does not give sufficient information for a study of this kind.

b. It is highly desirable that a detailed study be made in order that we may know whether or not we are unjustly maligned as to our maternal mortality.

c. We recommend that a questionnaire be developed and an analysis be made by a committee appointed by the president of the Indiana State Medical Association.

d. We further recommend that blanks for this purpose be furnished to county secretaries so that members having maternal deaths may fill out and mail to the state secretary this information.

e. In order that our data be worthwhile we recommend that this study embrace a five-year period.

Respectfully submitted,
J. R. PHILLIPS, M. D., Chairman.
L. H. ALLEN, M. D.
R. W. SHANKS, M. D.

REPORT OF DIPHTHERIA PREVENTION COMMITTEE

House of Delegates, Indiana State Medical Association:

Gentlemen: The Diphtheria Prevention Committee has continued the activities of the last three or four years, inasmuch as it has kept records of the deaths and cases of this disease, and has reported each month to the Journal in the special diphtheria article.

We are very happy to report that for the first six months of the year there were fewer deaths from diphtheria than any year in the history of the state, although that number is not much less than it was for the years 1930 and 1931. Last year at this time there were definitely more cases and deaths than this year, and so we have reason to believe that diphtheria is again on the decline, following the moderate rise of last year.

The committee wishes to continue its policy of allowing each community to carry out its own diphtheria prevention measures, but urges that the following principles be observed whenever possible.

1. That all children above six months of age be immunized against diphtheria, either by the use of toxoid or toxin-antitoxin.

2. That diagnosis be made by means of cultures and smears, and cases be reported to the local health officer at the earliest opportunity.

3. That cases not be released from quarantine until at least two consecutive negative cultures have been obtained, the cultures to be taken at intervals of not less than twenty-four hours.

4. That antitoxin be given as soon as possible after the clinical diagnosis, and that antitoxin not be delayed until the report from the laboratory is in hand.

5. When a clinical case is found in the community it should be carefully quarantined and isolated so as to prevent the spread of the disease.

Diphtheria is a strictly preventable disease and its continued presence in a community is a reflection upon that community and upon the medical profession.

THURMAN B. RICE, M. D., Chairman.
H. M. PELL, M. D.
W. M. STOUT, M. D.

REPORT OF COMMITTEE ON SECRETARIES' CONFERENCE

House of Delegates, Indiana State Medical Journal:

Gentlemen:

The Secretaries' Conference was held on January 22, 1933, at the Indianapolis Athletic Club with about 120 present. The meeting was held at this time on account of the legislature being in session.

Dr. Robb, of Detroit, Michigan, and Dr. E. H. Cary, of Dallas, Texas, gave very interesting talks on medical economics, as did also several of the secretaries. Everyone enjoyed the dinner.

On June 26, 1933, another Secretaries' Conference was held at the Indiana University School of Medicine. There were about seventy-five present. The purpose of this meeting was to acquaint the secretaries with the plan of the Indiana State Board of Health on problems of preventive medicine in Indiana.

Dr. Gatch, Dean of the Indiana University School of Medicine, opened the meeting, stating its

purpose, and turned the meeting over to Dr. A. M. Mitchell, Chairman. Dr. Thurman B. Rice, Dr. John H. Hare, and Dr. Clyde G. Culbertson spoke on this plan before dinner. Dinner was served gratis in the Riley Hospital.

After dinner Dr. John Hare, representing the Governor, gave a welcoming talk. This was followed by talks by Dr. J. H. Weinstein and Dr. W. D. Gatch.

Respectfully submitted,

A. M. MITCHELL, M. D., Chairman.
R. L. COMPTON, M. D.
L. P. HARSHMAN, M. D.
J. S. MCBRIDE, M. D.
A. L. SPINNING, M. D.
J. C. BURKLE, M. D.

LIST OF PRESIDENTS OF THE INDIANA STATE MEDICAL ASSOCIATION SINCE ITS ORGANIZATION

Name and Residence	*Elected*	*Served*
Livingston Dunlap, Indianapolis	1849	1849
William T. S. Cornett, Versailles	1849	1850
Asahel Clapp, New Albany	1850	1851
George W. Mears, Indianapolis	1851	1852
Jeremiah H. Brower, Lawrenceburg	1852	1853
Elizur H. Deming, Lafayette	1853	1854
Madison J. Bray, Evansville	1854	1855
William Lomax, Marion	1855	1856
Daniel Meeker, LaPorte	1856	1857
Talbott Bullard, Indianapolis	1857	1858
Nathan Johnson, Cambridge City	1858	1859
David Hutchinson, Mooresville	1859	1860
Benjamin S. Woodworth, Fort Wayne	1860	1861
Theophilus Parvin, Indianapolis	1861	1862
James F. Hibberd, Richmond	1862	1863
John Sloan, New Albany	1863	1864
John Moffet (acting), Rushville	1864	1864
Samuel M. Linton, Columbus	1864	1864
Myron H. Harding, Lawrenceburg	1865	1865
Wilson Lockhart (acting), Danville	1865	1866
Vierling Kersey, Richmond	1866	1867
John S. Bobbs, Indianapolis	1867	1868
Nathaniel Field, Jeffersonville	1868	1869
George Sutton, Aurora	1869	1870
Robert N. Todd, Indianapolis	1870	1871
Henry P. Ayres, Fort Wayne	1871	1872
Joel Pennington, Milton	1872	1873
Isaac Casselberry, Evansville	1873	1874
Wilson Hobbs, Knightstown	1873	1874
Richard E. Haughton, Richmond	1874	1875
John H. Helm, Peru	1875	1876
Samuel S. Boyd, Dublin	1876	1877
Luther D. Waterman, Indianapolis	1877	1878
Louis Humphreys, South Bend	1878	
Benj. Newland (acting), Bedford (v.-p.)	1878	1879
Jacob R. Weist, Richmond	1879	1880
Thomas B. Harvey, Indianapolis	1880	1881
Marshall Sexton, Rushville	1881	1882
William H. Bell, Logansport	1882	1883
Samuel E. Munford, Princeton	1883	1884
James H. Woodburn, Indianapolis	1884	1885
James S. Gregg, Fort Wayne	1885	1886
General W. H. Kemper, Muncie	1886	1887
Samuel H. Charlton, Seymour	1887	1888
William H. Wishard, Indianapolis	1888	1889
James D. Gatch, Lawrenceburg	1889	1890
Gonsolvo C. Smythe, Greencastle	1890	1891
Edwin Walker, Evansville	1891	1892
George F. Beasley, Lafayette	1892	1893
Charles A. Daugherty, South Bend	1893	1894
Elijah S. Elder, Indianapolis	1894	1895
Charles S. Bond (acting), Richmond	1894	1895
Miles F. Porter, Fort Wayne	1895	1896
James H. Ford, Wabash	1896	1897
William N. Wishard, Indianapolis	1897	1898
John C. Sexton, Rushville	1898	1899
Walker Schell, Terre Haute	1899	1900
George W. McCaskey, Fort Wayne	1900	1901
Alembert W. Brayton, Indianapolis	1901	1902
John B. Berteling, South Bend	1902	1903
Jonas Stewart, Anderson	1903	1904
George T. MacCoy, Columbus	1904	1905
George H. Grant, Richmond	1905	1906
George J. Cook, Indianapolis	1906	1907
David C. Peyton, Jeffersonville	1907	1908
George D. Kahlo, French Lick	1908	1909
Thomas C. Kennedy, Shelbyville	1909	1910
Frederic C. Heath, Indianapolis	1910	1911
William F. Howat, Hammond	1911	1912
A. C. Kimberlin, Indianapolis	1912	1913
John P. Salb, Jasper	1913	1914
Frank B. Wynn, Indianapolis	1914	1915
George F. Keiper, Lafayette	1915	1916
John H. Oliver, Indianapolis	1916	1917
Joseph Rilus Eastman, Indianapolis	1917	1918
William H. Stemm, North Vernon	1918	1919
Charles H. McCully, Logansport	1919	1920
David Ross, Indianapolis	1920	1921
William R. Davidson, Evansville	1921	1922
Charles H. Good, Huntington	1922	1923
Samuel E. Earp, Indianapolis	1923	1924
E. M. Shanklin, Hammond	1924	1925
C. N. Combs, Terre Haute	1925	1926
Frank W. Cregor, Indianapolis	1926	1927
George R. Daniels, Marion	1927	1928
Charles E. Gillespie, Seymour	1928	1929
Angus C. McDonald, Warsaw	1929	1930
Alois B. Graham, Indianapolis	1930	1931
Franklin Smith Crockett, Lafayette	1931	1932
Joseph H. Weinstein, Terre Haute	1932	1933

EXHIBITORS 1933 SESSION

French Lick, Indiana

Booth No.

3. Pitman-Moore Company....Indianapolis, Ind.
4. Kellogg Company.....Battle Creek, Mich.
5. W. D. Allison Co.....Indianapolis, Ind.
6. Horlick's Malted Milk Corp.....Racine, Wis.
7. Medical Protective Company of Fort Wayne Wheaton, Ill.
9. Akron Surgical House.....Indianapolis, Ind.
10-11. Merck and Co., Inc.....Rahway, N. J.
12. Mead Johnson & Company...Evansville, Ind.
14. R. B. Davis Company.....Hoboken, N. J.
16. H. J. Heinz Company.....Pittsburgh, Pa.
17. Gerber Products Co., Div. of Fremont Canning Co.....Fremont, Mich.
18. Mellin's Food Company.....Boston, Mass.

Booth No. 3—Pitman-Moore Company, Indianapolis

Our exhibit will consist of several of our well-known specialties which have been offered to the medical profession in Indiana and many other states for several years, including Siomine Capsules; Oxiphen Tablets; Cupritone; standardized Digitalis Tablets; as well as Cytinzyme and Cytinzyme with Iron and Manganese, two of our newer products, the former

recommended for the remission of pernicious anemia and the latter for secondary anemia. We will also exhibit Liver Extract in ampoule form for the physician who wishes to take care of his pernicious anemia cases by hypodermic medication.

Mr. Crosby Bartlett and the writer, Merrill J. Brown, will be in attendance.

Booth No. 4—Kellogg Company, Battle Creek, Michigan

The Kellogg Company, manufacturer of breakfast cereals for twenty-five years, will exhibit in Booth No. 4. Several years ago Kaffee Hag Coffee was added to the list of Kellogg products. Kellogg's All-Bran and Kaffee Hag Coffee are the two products of special interest to the medical profession. All-Bran contains valuable quantities of assimilable iron and Vitamin B, and because of its bulk it is valuable in correcting cases of atonic constipation. Kaffee Hag Coffee has been accepted by the Committee on Foods of the American Medical Association as being a coffee free from caffeine stimulation. The beverage is especially desirable to suggest for diets where an ordinary coffee or tea is forbidden. Kaffee Hag Coffee and cookies made with All-Bran will be served at the booth. Mrs. Winefred Loggans of the Home Economics staff will be in charge.

Booth No. 5—W. D. Allison Company, Indianapolis

The W. D. Allison Company, who have long been manufacturers of physicians' high-grade wood office furniture, have on display their entire new line of popular-priced Metropolitan furniture for the physician's treatment room.

Be sure to see the new Ramsey pediatric table, shown for the first time at this convention.

By all means, visit booth No. 5 and acquaint yourself with this beautiful and practical new line of furniture and the remarkably attractive prices. Mr. E. W. Roehm will be in charge.

Booth No. 6—Horlick's Malted Milk Corporation, Racine, Wisconsin

Horlick's Malted Milk Corporation, in Booth No. 6, will exhibit Horlick's, the Original Malted Milk. and Horlick's Malted Milk Tablets, both products in natural and chocolate flavors. Recent experiments have shown that the regular use of Horlick's not only definitely improves the appetite but also builds strength and resistance to colds and other diseases.

Dr. G. A. Glasgow will be in charge. All delegates to the convention are cordially invited to visit this exhibit.

Booths 10 and 11—Merck and Co., Inc., Rahway, New Jersey

In the Merck booth will be displayed such well-known preparations as: Pyridium for the treatment of urinary infections; Neoarsphenamine for the treatment of syphilis; Tryparsamide for the treatment of paresis; Stovarsol for amebic dysentery; Digitan for heart diseases; Erythrol Tetranitrate for hypertension; Bismosol, a water soluble preparation for intramuscular use in syphilis; and Arsenoferratose, a palatable blood building tonic. There will also be shown a number of new preparations such as: Clymocol for the extemporaneous preparation of stable surgical solutions. The Merck booth is always an attractive center of interest and will be in charge of Mr. Gaffney who will give you full information on the above preparations.

Booth No. 12—Mead Johnson & Co., Evansville, Indiana

Mead Johnson & Company will have on exhibit its complete line of infant diet materials including Mead's Dextri-Maltose, Mead's Newfoundland Cod Liver Oil, Mead's Viosterol in Oil—250D, Mead's A-D Viosterol in Halibut Liver Oil—250D, Mead's Undiluted Halibut Liver Oil, Mead's Brewers Yeast Powder, Pablum, Mead's Cereal, Mead's Powdered Whole Milk, Mead's Powdered Protein Milk, Mead's Powdered Lactic Acid Milk, Alacta, Recolac, Casec and Sobee.

There will be for the examination of physicians a complete line of Mead's services such as diets for older children—height and weight charts, etc., all of which are free to members of the medical profession in any quantity desired.

Representatives will be on hand to discuss the application of any of the Mead products to infant feeding problems.

Booth No. 14—R. B. Davis Company, Hoboken, New Jersey

COCOMALT—the delicious, satisfying, creamy, chocolate flavor food drink will be served to visiting physicians and their friends at Booth No. 14.

Keep step with COCOMALT and enjoy its fine flavor, delicious and nourishing qualities.

COCOMALT adds over 70 per cent to the caloric value of milk with which it is served. It increases the protein content 45 per cent, mineral salt content 45 per cent (calcium and phosphorus) and the carbohydrate content 184 per cent. It also contains a rich supply of calcium, phosphorus and Vitamin D—thus assuring the efficient utilization of the calcium and phosphorus and the building of them into strong bones and sound teeth.

One serving of COCOMALT (1 oz.) is equivalent in Vitamin D potency to two-thirds of a teaspoonful of standardized cod liver oil.

We shall be pleased to have you stop and taste the deliciousness of COCOMALT for yourself—so that you may judge of its quality and flavor.

Our representative will be very happy to answer any questions concerning COCOMALT.

Booth No. 16—H. J. Heinz Company, Pittsburgh, Pennsylvania

The products on display at the Heinz Booth that will be of special interest to physicians are the Heinz Strained Vegetables. These vegetables have been approved by the Committee on Foods of the American Medical Association, and the advertising literature on these products was prepared under the supervision of the same committee.

If any physicians attending the convention are not familiar with these new products, the Heinz representative, Tom Foster, will be glad to answer any questions the doctors may wish to ask.

Cold Tomato Juice will be served by a Heinz demonstrator during the convention; and if the physicians will leave their names and addresses at the Heinz Booth, samples of other products will be sent to their homes later.

Booth No. 17—Gerber Products Co., Division of Fremont Canning Co. Fremont, Michigan

The new Gerber Product is Cereal cooked in whole fresh milk and strained, ready for feeding. The combination of whole grain cereals, added wheat germ, cooked in whole fresh milk and then strained so as to retain the nutrients of the whole grain yields a food high in vitamins and minerals. The cereal is of such fineness that clinical trials with infants four and five weeks of age, who had been difficult feeding cases, have shown good results.

Analyses, booklets, and a display of all Gerber Products, Cereal, Vegetables, and Prunes, will be shown at the booth, No. 17.

Booth No. 18—Mellin's Food Company, Boston, Massachusetts

The Mellin's Food Company has recently made available to physicians a new formula card for infant feeding which will be shown in their exhibit in Booth No. 18. This card has been prepared after extensive conferences with many authorities and is based on their collective opinions. The Mellin's Food Company believes that the formulas and other suggestions are in accord with current scientific knowledge and practice and represent safe and adequate feedings for average normal infants. Their distribution is limited to physicians, as is all the company's advertising.

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OF THE

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DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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SEPTEMBER, 1933

EDITORIALS

OUR PRESIDENT

Joseph Hamilton Weinstein, M. D., president of the Indiana State Medical Association for 1933, first saw the light of day in Piatt County, Illinois, July 16, 1876. His parents came to Indiana some two years later, choosing Terre Haute as their home, and "Joe" has since lived in that city.

It is but natural that he should have chosen medicine as his profession, since his maternal grandfather and his father were practicing physicians; J. B. Hamilton graduated from Jefferson Medical College in 1836, and his father, L. J. Weinstein, received his diploma from Miami Medical College in 1872; twenty-five years later the same school awarded the degree of Doctor of Medicine to our president.

At an early period in his medical career "Joe" assumed an active role in the affairs of his profession in Indiana, having been named as Councilor for the Fifth District in 1904, which title he held, with the exception of the World War period, until 1930. During this period he served in various other official capacities, being successively made president of the Vigo County Medical Society, the Terre Haute Academy of Medicine, and the Aesculapean Society of the Wabash Valley.

An early enlistment in the Medical Corps of the United States Army found him commissioned as captain and assigned to surgical service in Base Hospital No. 86, Mesves-Bulcy, in July, 1918. He became chief of the surgical service in this base hospital in November, 1918, continuing in that capacity until his discharge in June, 1919.

Dr. Weinstein is a member of the Vigo County Medical Society, the Indiana State Medical Association, the American Medical Association, the Terre Haute Academy of Medicine, the Aesculapean Society of the Wabash Valley, the American College of Surgeons and the Staff of Union Hospital, Terre Haute. He was chosen as president-elect two years ago and at once began to demonstrate the fact that this was to be no empty, idle honor; he began a period of intense activity that has not ended and will not end until he shall have visited every section of his own Indiana. We used to pride ourselves on our acquaintance with the medical men of Indiana, but now take off our hat to "Joe" who undoubtedly has met more of our membership than any other person. And this thing of meeting Joseph Hamilton Weinstein is no ordinary event; his inimitable smile and the hearty handclasp at once attracts, and in a very short time he has numbered another among the host of friends of which he may so justly boast.

We thought that some of our former presidents had set a fast pace, but Dr. Weinstein has outdistanced all others in the amount of territory covered, in the addresses he has made, and in the monthly letters to the profession, via THE JOURNAL.

Without doubt, the finest piece of work Dr. Weinstein has done in recent years was that of his appearance before the Shannon Congressional Committee, at South Bend, where he presented a most forceful argument against what the medical profession universally believed to be a most unfair sort of competition, in the matter of hospitalization of ex-service men with non-service-connected disabilities. Practically the entire address appeared in the public press of almost the whole nation, and the medical press was a unit in the declaration that this was the most cogent argument ever presented in connection with that very grave problem.

The medical profession owes much to Joseph Hamilton Weinstein, and THE JOURNAL is most appreciative of this opportunity to record a few of his activities, and to accord him our fullest meed of praise.

THE HEALTH EXHIBIT AT THE STATE FAIR

This year sees a new departure in medical and health work in Indiana. We are planning an exhibit at the State Fair in the interest of legitimate health work and organized medicine. Heretofore, there has been nothing of this sort there except the Baby Show, under the auspices of the former Division of Infant and Maternal Welfare of the State Board of Health, and a small exhibit put on by the medical school in the Indiana University building.

The Baby Show has been repeatedly criticized from several angles. In the first place, it claimed to be highly scientific, when actually nothing could have been more unscientific than to have graded the babies on the basis of 1,000 points, and then carry the points to five decimal places in addition. We would say that to grade a baby in terms of eight decimal places is going a bit strong. Furthermore, we question the wisdom of bringing chil-

dren of ages commonly examined, from all corners of the state and tossing them into a mêlée, such as the baby building usually presented.

Instead, the two buildings and the two playgrounds which have been provided by the State Board of Agriculture, will be used for a much more dignified and logical purpose. The front building will house the exhibits of the Division of Public Health (the State Board of Health). Each Bureau in that Division will have a booth and will demonstrate to the public its activities and ideals. The object is to bring to the people a cross-section of the activities of that Division. An effort will be made to cut a window into each office and laboratory in the Statehouse Annex so that the public may look and see what is being done.

The back building is being turned over to a committe appointed by Dr. J. H. Weinstein, President of the Indiana State Medical Association, for the purpose of showing to the public the methods and ideals of organized medicine, and related branches. According to the present plan there will be seven exhibits in this building. One space will be given to the American Medical Association, and they have promised to put an exhibit in it. Another booth will house the Indiana State Medical Association, and it is planned to assign one booth each to the Indiana State Dental Association, the Indiana State Nurses Association, the Indiana Hospital Association, the Indiana Tuberculosis Association, and the Indiana Pharmaceutical Association for their various exhibits.

In playgrounds adjacent to the buildings small children will be checked and turned loose to play in carefully guarded and fenced grounds, where they will be under the care of matrons and nurses. Two grounds are available for this purpose so that the children may be divided on the basis of age. There will also be six to ten beds for babies and small children, who can be taking their naps while their mothers see the Fair. Immediately joining the two buildings is the brick Red Cross Hospital, which is, of course, not used for exhibit purposes, but only for the care of those persons who become ill, tired or are injured.

We seriously doubt if there is a more attractive medical unit on any fair ground in the United States. The three buildings are of pleasing appearance, being made of brick and glass. They are well equipped for their purpose, and probably have the best location on the grounds. We are planning to make this a regular feature of the Fair, and hope that it will receive the patronage of the profession and the public. Lectures will be given by prominent medical men of the state each day. A few of those men will be taken from Indianapolis, but we are hoping to use speakers from every section of the state. If you are asked to give a little time to the exhibit in the interest of organized medicine and public health, we hope you will see fit to co-operate.

The plan of having medical exhibits at the State Fair has been found to be very successful in many states, especially in Nebraska. Those in charge of the exhibit have consulted the authorities of the American Medical Association and the Nebraska State Medical Association, in order to get all the assistance possible. With the right kind of co-operation this can be made an important factor in the education of the public on medical lines, and can also be made a means of inspiring confidence in the great profession to which we belong.

HEREDITY AND PREVENTION OF DISEASE

The importance of heredity in the etiology of disease may be controversial but the importance to the individual influenced by it is very real. There is no doubt that when heredity is studied more thoroughly in human beings in relation to disease, as it is in lower animals where good stock breeding is an art and a necessity, it will gain in importance.

The late A. S. Warthin of the University of Michigan, in discussing cancer of the stomach, stated that "The whole explanation of the carcinoma neoplasm rests upon a constitutional hereditary basis and the problem of ulcer and gastric cancer rests upon the same basis."

There can be little doubt that heredity is of much importance in the problem of schizophrenia.

C. B. Davenport and associates, in a recent number of the *Archives of Otolaryngology*, state, "By a rough estimate, about 0.2 per cent of the whole population of the United States is otosclerotic. In certain fraternities 100 per cent are otosclerotic. The hereditary factor is thus obvious." They state that deafness may begin from the 4th to 55th years, that about twice as many females as males are affected, that when both parents are otosclerotic nearly all the daughters are otosclerotic and about two-thirds of the sons are affected in like manner.

In a recent address before one of our local medical societies, Dr. H. B. Weiss, of Cincinnati, directed attention to the great importance of heredity in relation to essential hypertension.

The postulate that "one dies of the disease with which he is born" will no doubt become nearer the truth as "life expectancy" increases.

Frequently, in the type of condition where the disease has become well manifested, little or nothing can be done of a curative nature, but, when we enter the field of preventive medicine and consider the children, much may be done in certain of the disease entities. Surely, if it is true that cancer of the stomach, for instance, is a hereditary disease, the children of such a family should be directed to put themselves under good medical care when gastro-intestinal disorders arise.

In the case of schizophrenia, unless it is recognized in its early stages, it becomes a most distressing disorder to deal with. The family history here might put one on guard.

If it is true that otosclerosis is due to an hereditary dysfunction of the calcium metabolism, there may be some hope that investigation of the calcium metabolism in the child of otosclerotic patients may lead to some preventive results. The importance of calcium in this condition seems reasonable since the teeth of those developing otosclerosis go to ruin early in life and since pregnant women who are otosclerotic apparently suffer more than usual from calcium deficiency.

If there is a specific cause of essential hypertension it is not known. All of the often worried-about factors such as tobacco, alcohol, and intense living, do not appear to be important from the etiological standpoint, but they do not help the course of the disease. It would seem that the important thing from the preventive viewpoint at the present state of our knowledge is to realize that where parents have marked hypertension and die of apoplexy or myocarditis in middle life, their children may look forward to a similar condition for themselves by the time they are forty. If they are made to realize this they may order their vocations to live a peaceful, contented and longer life, providing for plenty of rest with their labors, not too much responsibility to worry about, and the avoidance of infections.

Even the rest of us who live intensive lives might do better for ourselves if we took a vacation more than once in a while with more fishing and golf and less driving at seventy miles an hour from here to there; if we took the time to smoke a pipe rather than a pack of cigarettes; if we took a regular mid-day siesta rather than hurried to the luncheon club and, even as Sir William Osler did, if we carried with us to read and re-read such a book as Thomas Browne's *Religio Medici*. Browne, writing in 1643, offers as ending for his book this prayer:

"Bless me in this life with but the peace of my conscience, command of my affections, the love of thy selfe and my dearest friends, and I shall be happy enough to pity Caesar. These are O Lord the humble desires of my most reasonable ambition and all I dare call happiness on earth: wherein I set no rule or limit to thy hand or providence, dispose of me according to the wisdom of thy pleasure. Thy will be done, though in my own undoing."

GROUP HOSPITAL INSURANCE

The August number of THE JOURNAL carried the most informative article on this subject that has ever appeared in the medical press. That it might have more than ordinary publicity, our Executive Committee has sent a copy to all state association secretaries and to all state journals.

When the executive officers of at least ten of the larger insurance companies of the country are agreed that group hospital insurance is taboo, so far as they are concerned, it stands to reason that there must be many flaws in the argument produced by those engaged in selling these special contracts; if such a procedure were a practical one and financially sound there is not the slightest doubt but that the larger insurance companies would long since have taken over that field.

A statement of one life and health insurance company is most intriguing: "Our experience for the last two years as a health and accident company is that we ought to be more properly classed as a Red Cross Society or a Community Chest!" Another, whose experience seems to be very broad, makes the observation that "loss ratios increase tremendously on any new form of policy during the first four or five years. In other words, the average person with a new form of policy does not become 'insurance conscious' until he has had the policy a year or two—then the claims begin to come in." Both these statements are most illuminating, particularly the latter; the first year of operation may prove lucrative but once the policy holder becomes "insurance conscious" the drain on the company's resources will prove too much for the income.

Every member of the Indiana State Medical Association should file THE JOURNAL for August; true it is that so far we have escaped the hospital insurance peril, but rumblings and rumors are to the effect that certain commercial corporations still cast longing eyes toward Indiana and it is not at all certain that they will not again essay an entry into our state.

THE PUBLIC HEALTH NURSE

The keynote of the newer relation which exists among the Indiana State Medical Association, the Indiana Division of Public Health, and the Indiana University School of Medicine, is understanding and harmony among the various organizations taking part. Unless the different medical and health agencies of the state can work together for a given purpose toward a definite end, a large part of the effort expended by the one will be counteracted by the other.

There are still several objectives to be accomplished in this program of harmony. We doubt if there is any more pressing one, however, than the need for better understanding between the doctors of the state and the public health nurses. The writer of this editorial is greatly impressed with the belief that the public health nurse has come to stay, and further that she performs a function in the community which can be exercised by absolutely no other person. She can be of the greatest possible benefit to the community and of tremendous help to the physician in charge, or she can be a cause of an enormous amount of trouble and misunderstanding. Whether she is one or the other depends upon whether strictly ethical lines are followed both by the nurse and the physician. We have no doubt that in many instances the breaches of ethics have been the result of the failure of

someone to understand exactly what the nurse may properly do. In some instances, no doubt, the nurses have been inadequately trained for the work they are doing and have been quite unfamiliar with the proper limits of their duties in the community. It is the unwritten law of nursing ethics that the nurse may not diagnose or treat cases on her own responsibility. In spite of this fact, however, one hears at every medical meeting a great many complaints against one public health nurse or another on this score. In some instances undoubtedly the complaint is accurate. In other instances there is no doubt that the story is one which has been told from mouth to mouth until it would be impossible to vouch for its authenticity. The result is that doctors and nurses are to a considerable extent fussing at one another when they should be working for the good of the patient and the community.

It occurs to us, in the light of these facts, that an effort should be made by the medical and nursing professions to get together on this matter and work out a plan whereby much of this trouble might be corrected. Would it not be a good thing for the president of the Indiana State Medical Association to appoint a committee of physicians who would meet with a committee of public health nurses and draw up a set of standing orders and principles for the guidance of public health nurses in the field? These principles could then be distributed to the nurses over the state who are doing public health work, with the strong hint that they be rigidly observed if the nurse would wish to avoid the displeasure of the organized medical and nursing professions. If it is not desirable that a committee be appointed for this purpose, the responsibility for such work might be turned over to the Public Relations Committee.

In case any doctor should know of a case in which these rules had been violated, it would be his bounden duty to report the matter over his signature to the joint committee, whose function it would be to investigate such a report and take such disciplinary action as might be indicated. In case a physician could not make the report over his signature, professional ethics and common decency would require that he say little or nothing about the matter and, therefore, not serve to start or propagate the vicious stories which are doing so much to undermine the confidence of the medical profession in public health nursing.

In the event the doctor does have a complaint against the nurse, common decency and the ethics of a gentleman as well as of a physician, would seem to indicate that he should go to the nurse directly, find out the facts in the case, and make it plain to her wherein she has transgressed if she has done so. It is pretty certain that a large percentage of the difficulties could be easily smoothed out if this were done. It is not fair to go over the nurse's head with the complaint, and thereby injure her reputation and her chances for holding her job, unless an effort has been made to get her version of the story.

If the physicians of a given community would not care to send their complaints to a central committee, it would seem quite proper that each county appoint its own committee for investigating such complaints. In such cases it would seem to be only fair that the nurse or her representatives be present either on the committee or at the hearing. It is extremely important that the authorship and authenticity of every one of these ugly rumors be determined.

By this means it should be possible to investigate any rumors concerning this or that public health nurse, who is said to have been guilty of unethical conduct. If she is guilty she should be reprimanded, and if repeatedly found guilty she should be discharged. If she is not guilty, justice demands that she not be persecuted by persons dealing in ungrounded rumors and tales. If the difficulty is merely one of misunderstanding, the committee would serve a most useful purpose in straightening out the matter if possible, and defining the lines which ethical nursing should follow. We feel that this is a most needed undertaking in the light of the recent success in bringing about harmony among the other groups, which until recently have been viewing each other with suspicion and distrust, and should like to present the matter for the consideration of the delegates at the coming meeting at French Lick.

EDITORIAL NOTES

DEAR DOCTOR:

THE JOURNAL and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital.

We invite and urge you to use this Service.

It is absolutely *free* to you.

The Cooperative Bureau is equipped with catalogues and price lists of manufacturers, and can supply you information by return mail.

Perhaps you want a certain kind of instrument which is not advertised in THE JOURNAL, and do not know where to secure it; this Service Bureau will give you the information.

Whenever possible, the goods will be advertised in our pages; but if they are not, we urge you to ask THE JOURNAL about them, or write direct to the Cooperative Medical Advertising Bureau, 535 N. Dearborn St., Chicago, Illinois.

We want THE JOURNAL to serve *you*.

THE TIME: Monday, Tuesday and Wednesday, September 25th, 26th and 27th, 1933.

THE PLACE: French Lick, Indiana.

THE EVENT: The annual session of the Indiana State Medical Association.

PRESS reports carry a most interesting story regarding the sizable verdict of $15,000 awarded in a Marion County Court, based on a suit for loss of

vision. It seems the plaintiff purchased a proprietary depilatory from an Indianapolis store, said article containing thallium acetate. Following its use she had an infection that resulted most disastrously, so far as her vision was concerned. The case seems to have excited more than usual interest among the members of the local profession, judging from the discussions we heard before the case went to trial, and the award of the jury will probably further excite no little degree of interest. Thallium acetate has long been known to be a most dangerous substance and just why a manufacturer should be permitted to incorporate it into a depilatory—or any other form of cosmetic—is quite beyond us.

A RAPIDLY growing practice and one that should not be condoned by physicians was recently described by one of our druggist friends. He remarked that it was a daily occurrence to have a customer come in and, reading from a prescription, order a drug or a combination of drugs. One can readily see just how vicious such a practice might become in certain instances and the blame attaches to the doctor in practically every instance. A little more care in writing the prescription, using accepted abbreviations and nomenclature, will make it impossible for the patient to do other than to present the prescription and have it filled in the customary manner. A prescription is an order for a specific medication and every precaution should be taken to see that it is prepared in accord with the wishes of the prescribing physician.

A WHILE ago we made some comment on the receipt of papers from men remote from Indiana, accompanied by a request that the same be used in THE JOURNAL. Needless to say these are at once returned to the authors. Exceptions of course are made in case the author is well known to us and has a real message. Just recently we received such a communication from a man in an eastern state, enclosing a paper that at first glance had the ear marks of some merit, but a careful checkup showed that it was a "booster" for a preparation that had not been accepted by the A. M. A. Council on Pharmacy and Chemistry; in fact, the product has not as yet been submitted to the Council. We know nothing as to the local standing of the author nor as to his purpose in writing the article, then submitting it to a Journal some thousand miles away, but we do have a personal notion as to what it is all about.

Among the most interesting comments on the article on Group Hospital Insurance in the August number of THE JOURNAL is an editorial in the Terre Haute *Star*, of August third, from the pen of the editor, James Benham. He quotes liberally from the Journal article and his comments are very much worth noting. His concluding statement follows: "One can assume from such statements that group hospital insurance is not feasible, or at least not at any such rates as are proposed under contracts now being offered. With the old and well established companies now refusing to write such policies, it behooves anyone to know what he is getting before entering into a contract." It is indeed refreshing to read such comment in the public press; to know that lay editors are awake to the fact that all the ballyhoo attending the release of the final report of the Committee on the Costs of Medical Care was not so well founded, after all. We sincerely thank Editor Benham for so concisely presenting this interesting and intensely educational editorial to his readers. Would that other editors might be equally alert to the dangers attending present group hospital insurance proposals.

THE medical press "notes with alarm" the increasing rates for indemnity insurance in various states. We are advised that one company has increased its rates, in Marion County, to $35 for $5,000 to $15,000 limits, while another standard company advises us that its rate of $20 for basic limits of $10,000 to $30,000 will continue, at least for the time being. However, they make it very plain that the business, at present, is most unprofitable as a nation-wide proposition. They make the following statement: "You will be interested to learn that Indiana is one of only five states where both the volume and the experience have been so satisfactory that we have been able to continue the basic premiums and policy limits above described." It certainly is refreshing to know that our own Indiana stands so high in the list of states in the matter of malpractice suits; we had feared she was far down in the list. But the fact remains that too many of these suits are brought about by careless remarks of medical men, themselves, as is so well pointed out in *Colorado Medicine* for July. With the exercise of a little thought and a more judicious use of expression, coupled with a more decided co-operation, we can further reduce the hazard and thus assure Indiana physicians of no step-up in insurance costs.

"COCKTAIL Anesthetic, Radio Knife At Clinic Here." So reads the heading of a lurid tale as gleaned from a daily paper in one of our larger cities. It seems that the "inventor" of this new (?) form of anesthesia, said to be a Chicago physician, but whose name does not appear in the 1931 A. M. A. directory, chose to "strut his stuff" in one of our Indiana cities. That he got away with his advertising stunt is evidenced by the two-column write-up accorded him. Very appropriately, the article appeared on the pink sheet of the paper.

The other member of the sketch, the radio knife man, also broke into print in the same article, but "only after he had told about Dr. ———'s invention could Dr. ——— be brought to talk about his own, the radio knife." Modest chap, this; but, boy, when he did consent to talk, he said plenty! As a matter of cold fact, we are getting just about filled up with the publicity stunts some of our neighbors from Illinois pull off in Indiana. Whether they think they are somewhere down in the sticks, or whether they have discovered that the Indiana press readily falls for this sort of a game we do not know. We have made specific complaints to the Council of the Chicago Medical Society, all to no purpose. The Indiana physicians who loaned themselves to this publicity stunt have in no wise improved their local status.

We trust that every member will read the complete report of the Executive Committee in the current number of The Journal. It is the most exhaustive report ever presented by this Committee; in fact, it is a cross-section of the entire activities of the Indiana State Medical Association for the past year. One of the outstanding bits of information contained therein, and one that calls for no little consideration at the hands of the general membership, is the reference to the travel activities of President Weinstein. He states that, during his terms as president-elect and president, he has traveled some sixteen thousand miles, visiting county and district medical societies. We'll bet that his speedometer has missed many hundreds of miles at that. We of Scottish decent are prone to reduce these figures into terms of gallons of gas and quarts of oil; doing so, we arrive at an interesting set of figures; all of which leads to the suggestion that the budget committee would do well to give some consideration to the subject. This presidential job is getting to be more than a job—it is a task—if future presidents follow the pace set by Drs. Crockett and Weinstein; comparatively few of our members can afford the time away from their practices. Of course, during these past two years when the various economic problems were many and extremely acute, it behooved the head of the Association to do all within his power to assist the various societies which were giving the Macedonian cry; it seems more than probable that the need for a "flying squadron" will not be so acute in coming years; nevertheless, we believe a proper appropriation should be made to cover the actual expenses incurred by our chief executive.

A most interesting report comes from the Seventh Councilor District; it hits at an evil that seems to be growing too rapidly in the Indiana profession. We, of course, refer to the announcement recently sent to various Indianapolis manufacturers, setting forth a "new plan" of handling medical and surgical cases among their employees. It is purely a commercial proposition and it would seem that medical men would be slow to enter into any such undertaking, especially those who always have been more or less active in organized medicine. It is but another form of medical and surgical insurance, the whole plan of which was thoroughly discredited by an article in the August number of The Journal. When the larger insurance companies decide that they cannot successfully engage in such undertakings, it should be apparent that a smaller group can not make a success of it. Nor is this evil confined to the capital city. We have had similar complaints from various other of the large cities in Indiana, all of the same general tenor—price cutting, panel systems, and all that sort of thing. In one of our larger cities an oculist admittedly does refractions and furnishes glasses *for considerably less than ten dollars!* When taken to task for it, his excuse was that he had to compete with the optical parlors! He did admit, however, that he was not using first-class materials in either frames or lenses. The underlying evil of all this lies in the fact that medical men who should know better will lend themselves to such a prostitution of their profession. It is pathetic that they should become so panicky over personal economic conditions that they are willing to sell their very professional souls for a pittance. Why not be men; why not "take it on the chin, upstanding!" "Business" has been rotten, and collections have been worse, but why in the name of heaven should we cut rates, work for a pittance, or sell our professional souls during times of stress? The trades unions have a specific name for those who engage in such practices—a name that seems very applicable in the present instance.

After having spent some twenty-eight hours at the Century of Progress Exposition (no, we have not yet seen the Streets of Paris), we believe we are qualified to comment on same. Our advice is, *by all means see the Fair!* It is a wonderful exhibition and is worth the time and expense necessary to cover it. To the medical man the Fair offers much; the Hall of Science is a veritable treasure house for those interested in scientific affairs. The medical exhibits are a credit to the profession, their educational features being of the highest order. There is surprisingly little of commercialism about these exhibits, and the gathering hosts surely do "take" to them, for the exhibit hall is crowded continually. Some of the larger industrial corporations have fairly outdone themselves in arranging their exhibits, as evidenced by a large motor corporation which has a complete assembly line in operation for several hours each day; one

large tire maker also has a manufacturing exhibit which is very entertaining. The Horticultural Hall, one of the few major exhibits to which an admission fee is charged, is a most interesting exhibit, their out-door garden display being one of the most beautiful things we have ever seen. Intra-Fair transportation ranges from wheel-chairs and jinrikshas to over-size busses, and furnishes means of transport throughout the three mile stretch at very reasonable rates. Speaking of transportation, we would remind our folks that the tales regarding automobile travel to Chicago and the Fair are grossly exaggerated; we have heard stories to the effect that cars from outside Chicago are not allowed near the Fair, all of which is propaganda, imagination or something equally ethereal. One may drive his car right up to all the entrance gates (except Twelfth Street), and there find ample parking space at a reasonable rate. While those of us who attended the World's Fair of 1893 miss the Midway, yet the entertainment features of the present show are more than sufficient to sate the most ambitious Fair visitor. Refreshments of all sorts are available, ranging from the ubiquitous sandwich to the elaborate dinners served in the more pretentious places and, for the most part, the prices are those usually charged in various cities for similar service. By and large, we feel sure you will be well repaid for having spent a few days at the Exposition of Progress.

SECRETARIES' COLUMN

September 25th, 26th, and 27th will be big days for the doctors. French Lick with Pluto should give you the thrill of your life, so do not fail to come. All the doctors will be there. At this time the Flying Squadron will put on a good show both scientifically and economically. Take your wife along; she will enjoy French Lick. Brown's will probably be open, expecting the doctors to be good fish; well, let us tell them confidentially that all the doctors are broke. You know they are always the last to be paid.

Talking about collections—do you find them any better? Get busy and get all the money you can. The N. R. A. should help you out a lot, and it's good business to use a gentile collector.

At this writing the doctors and hospitals have not received any code from the Government. Do not take any part in this until you know what to do. The blanket code does not affect the professional men or nurses.

In the last issue of THE JOURNAL, Tom published several letters about group hospital insurance; read them. If this type of insurance is bad business for the insurance companies, then it is also bad business for the doctors. Any doctor who plays with this type of insurance will be sure to get his fingers burned.

At the meeting in French Lick there will be a round table talk. It is important that all the secretaries sit in on this talk; there will be a lot of good information passed out.

I wonder how many doctors have been suckers and have fallen for the following proposition. It hurt my dignity. A drug company's representative offered to give me all the samples of citrocarbonate I wanted; said I could give them to my patients and that said patients would have a nice bottle for the purpose of bringing me a sample of urine. The JOKER was that I was to *leave the label on the bottle!* We have been suckers for some drug houses for a long time. They get the doctors to use their stuff and then put it on the market, saying that it is endorsed by the medical profession, and sell to any one that will buy. I believe that the U. S. P. and N. F. have enough good drugs and preparations listed for any of our purposes. This also keeps the patients from having prescriptions refilled so often and from passing the prescription around to his friends. It also keeps them from buying ten or fifteen cents worth. If we will use the U. S. P. and N. F. I believe it will be dollars in the physician's pocket.

It is always a good thing, when you give a patient a sample of medicine, to remove the label. The label on the bottle is a boomerang to your business.

A representative from the State Board of Health gave a talk to the Kiwanis Club on Child Welfare at the request of the County Medical Society, and it was broadcast on the radio. Secretaries, let us see if we can not have more of this. A radio talk over WBOW was given by a county medical society on the "Health Side of Floods." I would like to hear more of these talks in the state sponsored by the county medical society.

Remember French Lick, September 25th, 26th, and 27th.

A. M. MITCHELL, M. D.

THE PRESIDENT'S PAGE

Committee Reports

I anticipate with a great deal of pleasure in the willing cooperation of so many of our loyal members, and pride in the knowledge of work well done, the publication in this number of the reports of our committees.

These men have labored willingly, spent liberally of their money, and given freely of their time for the benefit of the entire organization. Each of these reports deserves a careful reading not only that you may acquaint yourself with the activities and accomplishments of the Association, but as a compliment to those who have been striving to do something for your good.

Following the annual session at French Lick, your president will begin the relinquishment of his robes of office, so they may be remodelled to fit your president-elect, Dr. E. E. Padgett.

Dr. Padgett has worked hard this year, has visited many of the county and district societies, attended many committee meetings, and has the work well in hand. With a full and complete understanding of all our problems, he is in position to carry to satisfactory completion our unfinished work.

Next year may see the climax of many of our difficulties, and the kindest thing I can wish for Dr. Padgett is that he may have the same cooperation and sympathetic support that has been given me this year.

Annual Session

On Tuesday of the French Lick meeting at noon will be held a round table conference on economic problems. This will be conducted by Dr. Padgett, and any questions to be asked, or announcements any member desires to make, will be welcome. All are not only invited, but are expected to be present.

If you have read thus far this monthly message, let me urge you, if you have not already done so, to read carefully the program of our annual session. You cannot afford to miss this meeting.

The Third District and the Orange County societies have prepared a social program and entertainment for the doctors, ladies and guests unsurpassed at any previous meeting, and I am quite sure you will admit the talent on the scientific program is all anyone could ask for. We believe the instructors could not have been more carefully chosen, nor the subjects to be presented more practical and interesting, and arrangements have been made for three hours each in medicine, surgery, and eye, ear and throat work for intensive postgraduate instruction.

Indigent Care

We hope by convention time to have completed a "code" with the Governor's Relief Committee that will apply to the state at large and that it will be accepted and adopted by all county societies.

The Governor has consulted with and taken advice from the State Medical Association in all matters medical. In compliment to him and as a duty to your officers and committees, it is incumbent upon all of us to support this agreement. Not every county, but every section of the state has had representation in this conference. A total of about fifty doctors has had a voice in this "code" prepared for the care of the indigent.

State Fair

We want as many doctors as possible to attend the state fair and give us their reactions to and their comments on our exhibit. This is a maiden effort, an experiment, and the members of the State Fair Committee will need all the moral support we can give them.

Public Health

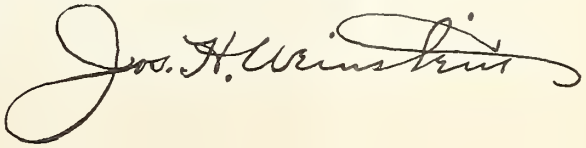
I have great confidence in our new public health plans. I have attended two lay meetings, and the speakers were not only enthusiastically received, but were requested to return and give more. This, I think, is sufficient indication that the public is anxious for knowledge and correct information from reliable sources.

N. R. A.

Headquarters office receives daily requests for information regarding a code for physicians under the N. R. A. At the time this is written neither the American Medical Association nor the Indiana State Medical Association has any information concerning it. Inquiry at Washington by person, letter and telegram has brought no response. Just as soon as any information is received, it will be sent to every county secretary. In the meantime do not sign any agreements not pertaining specifically to physicians.

Our Executive Secretary

I wonder how many of our members appreciate the loyalty and earnestness of our executive secretary? This has been a very strenuous year for him in our behalf, beginning with the legislature and continuing daily since, many nights also until midnight and occasionally later, as many of us can testify. Such loyalty as this is without price, money cannot purchase it, and we can only repay by expressing our appreciation and showing our willingness to assist in every way.



DIPHTHERIA REPORT FOR JULY, 1933

Seven deaths from diphtheria for the month of July is somewhat discouraging. This brings our total for the year to sixty-one which is two more than the lowest record that has been made, namely fifty-nine in the first seven months of 1931. Somewhat more alarming than the number of deaths is their distribution. Every one of them with the exception of one in Allen County is from a county which has had no deaths so far this year. We are wondering if this report is giving us a foresight of the coming year. Fayette, Noble, Orange, Randolph, Starke and St. Joseph enter the black list for the first time. We should like to caution the doctors and health officers of these counties to be on the alert. We must bear in mind that the biggest part of the diphtheria year is just ahead, namely October, November and December. Particularly do we wish to call the attention of northern Indiana to the diphtheria menace. Nearly all cases reported recently and all the deaths for July with the exception of one were in that half of the state.

There is still plenty of time to immunize children and have them ready for the big increase that comes immediately following the opening of school. Every child should be immunized against diphtheria before starting to school and it is even more important that the pre-school child should be immunized soon after he is six months of age.

A list of counties is shown indicating the number of deaths for the year so far and for the month of July.

County	Total for 1933	July, 1933
Allen	7	1
Bartholomew	1	0
Blackford	1	0
Daviess	2	0
Delaware	1	0
Dubois	1	0
Fayette	1	1
Fulton	1	0
Greene	1	0
Hancock	2	0
Harrison	1	0
Howard	1	0
Jackson	2	0
Knox	1	0
Lake	2	0
Lawrence	2	0
Marion	8	0
Monroe	1	0
Morgan	1	0
Noble	1	1
Orange	1	1
Parke	1	0
Pike	1	0
Randolph	1	1
Ripley	1	0
Shelby	2	0
Starke	1	1
St. Joseph	1	1
Sullivan	3	0
Switzerland	1	0
Tippecanoe	3	0
Union	1	0
Vigo	1	0
Warrick	1	0
Warren	1	0
Wayne	1	0
Wells	1	0
Vanderburgh	1	0
	61	7

DEATH NOTES

ZACK H. HAUSER, M. D., of Columbus, died August fourth, aged ninety-four years. He graduated from the Medical College of Ohio, Cincinnati, in 1866.

A. B. MENDENHALL, M. D., of Cicero, died July twenty-second, aged ninety years. Dr. Mendenhall was the oldest physician in Hamilton County. He graduated from the Cincinnati College of Medicine and Surgery in 1865.

DONALD H. DEAN, M. D., of Rushville, died July twenty-fifth, after an illness of several months. He had practiced medicine in Rushville for forty-one years. He graduated from the Chicago Homeopathic Medical College in 1889.

HOOSIER NOTES

DR. AND MRS. JAMES GRAHAM have moved from Knox, Indiana, to Pitcher, Oklahoma.

DR. O. M. GINGERICK has opened an office for the practice of medicine at Poneto, Indiana.

DR. EARL BAILEY has located in Bunker Hill where he will conduct a general practice.

DR. H. B. LINDSAY has opened offices in Washington, Indiana, where he will practice medicine.

MISS HILDA KAHAN AND DR. ARNOLD L. LIEBERMAN, both of Gary, were married August twenty-seventh.

Ida May Daubenheyer, wife of Dr. M. F. Daubenheyer, of Worthington, died August twelfth. Mrs. Daubenheyer had been ill for several years.

Dr. Omer Wooldridge, of Columbus, addressed members of the Columbus Rotary Club, July thirty-first.

Dr. H. P. Metcalf, of Rushville, has moved his office from West Second Street to the Odd Fellows Building.

Miss Ruth Johnson and Dr. L. H. Gilman, of Indianapolis, were married August twenty-third, in New York City.

Dr. Arthur Scudder has located at Brownsburg from where he will conduct a general medical practice.

Edward D. Gibson, of Jeffersonville, has opened an office for the practice of medicine at 428 Spring Street.

Dr. and Mrs. Edwin B. Boots, of Hobart, are the parents of a seven pound boy, born July twenty-fourth.

W. T. Lawson, M. D., of Danville, has moved his office from the square to his home in West Marion street.

Dr. and Mrs. Norman Reglien, of Michigan City, have moved to Three Oaks, Michigan, where Dr. Reglien will practice medicine.

Dr. William R. Tindall has located in Shelbyville where he is associated with his father, Dr. W. W. Tindall, in the practice of medicine.

Dr. W. E. Barnett has opened offices at Logansport where he will conduct a general practice, giving special attention to diseases of the heart.

The twelfth annual scientific session of the American Congress of Physical Therapy will be held in Chicago, September eleventh to sixteenth, at the Palmer House.

Miss Muriel Weeks, of Bedford, Massachusetts, and Dr. Bronson S. Ray, son of Dr. Herbert A. Ray, of Fort Wayne, were married in New York City, July twenty-eighth.

Dr. H. B. Ferrell, of Washington, was the principal speaker at the nineteenth annual Brown County reunion in Garfield Park, Indianapolis, August twelfth.

Dr. H. C. Wurster has reopened his office in Mishawaka after an absence of a year, during which time he has taken special work in diseases of the eye, ear, nose and throat.

Dr. John A. Flora, of Flora, has announced his intention of discontinuing his practice in Flora for the purpose of taking post-graduate work in New York for a period of two years.

The *Medical Woman's Journal* has broadened its activities to include the work of women in other scientific fields and has adopted the name *Medical and Professional Woman's Journal.*

Dr. J. L. Allen, of Greenfield, has been appointed assistant physician at the Indiana Reformatory at Pendleton. The appointment will not interfere with Dr. Allen's practice in Greenfield.

Plans for the year's work of the Woman's Auxiliary to the Indianapolis Medical Society were made August eleventh at a meeting sponsored by Mrs. William F. Tomlin, president of the Auxiliary.

Dr. Katherine Jackson has been named one of nine physicians on the staff of the Fort Wayne Public Schools, being the second woman to be appointed to a position on the medical staff in the history of the city's schools.

Dr. Whitefield Bowers, of Michigan City, has received from the Metropolitan Life Insurance Company a medal with two gold bars attached, as a token of appreciation of his more than thirty years of service for the company.

Dr. M. Joseph Barry was made president of the Indianapolis Board of Health at the annual reorganization meeting held July twenty-first. Dr. L. A. Ensminger was made vice-president, and Dr. Herman G. Morgan was retained as secretary.

The Eleventh Indiana Councilor District Medical Association will hold its fall meeting October twenty-fifth, instead of October seventeenth as originally planned. The meeting will be held in North Manchester.

THE Lake County Medical Society had a picnic at the Turkey Creek County Club, in Gary, August ninth. It was a strictly "stag" party, with golf, ball, horseshoes and games in the afternoon, and dinner and entertainment in the evening.

THE American Social Hygiene Association will hold a regional conference in Indianapolis, October 12th to 14th. This conference will begin the last day of the meeting of the American Public Health Association, which will be held October 9th to 12th.

TWENTY-FIVE doctors and dentists and their families enjoyed a picnic supper at Danville, Indiana, July 28th, with members of the Hendricks County Medical Society as hosts. Following the supper, Dr. John Whitehead, of Indianapolis, addressed the guests.

DR. D. R. IVEY, of Royal Center, has been made president of the State Bank of Royal Center, to succeed the late A. R. Beckley. Dr. Ivey had been vice-president of the bank for several years. The bank recently has been elevated to class A under the requirements of the state.

DR. O. R. LYNCH, superintendent of the Logansport State Hospital, resigned his position recently. Dr. C. L. Williams, who was assistant superintendent of the Evansville State Hospital, has been made superintendent to succeed Dr. Lynch. The change became effective August 19th.

THE Noble County Medical Society was entertained by the Doctors Luckey, at Luckey Hospital, Wolf Lake, July twenty-seventh. Dinner was served at one o'clock, and a paper on "Quacks and Nostrums and What to do to Them," was presented by Mr. George F. Peabody, of South Whitley.

THE Hendricks County Medical Society met at Danville, July twenty-first, for a dinner meeting. Dr. John Whitehead, of Indianapolis, talked on "Anesthesias: Use of Both Old and New." Dentists of the county and their wives, together with the wives of the members, were guests at this meeting.

DR. HOMER G. HAMER, of Indianapolis, has recently attended the International Urological Congress in London. Dr. Hamer is a member of the organization which meets every third year, and the next meeting will be held in Vienna. Only nine Americans are numbered among the members of the organization.

DR. J. W. WARVEL, of North Manchester, Dr. R. D. McKay, of Lafontaine and Dr. William Pearson, of Wabash, were hosts to members of the Wabash County Medical Society at North Manchester, August second. George Peabody, of South Whitley, presented an interesting talk on "Quacks and Quackery."

DR. GEORGE B. DETAR, of Winslow, addressed members of the Gibson County Medical Society, August fourteenth, at Princeton. Attendance at the meeting numbered twenty-one. Dr. DeTar's subject was "Cholecystitis—Differential Diagnosis and Treatment." Luncheon was served the attending members by the Princeton Methodist Hospital management.

DR. W. R. DAVIDSON, of Evansville, has been reappointed secretary of the Indiana State Board of Medical Registration and Examination. Other members of the Board are Dr. J. W. Bowers, of Fort Wayne, president; Dr. F. S. Crockett, Lafayette; Dr. L. C. Sammons, Shelbyville; Dr. N. E. Harold, Indianapolis; Dr. C. J. Von Tilburg, Indianapolis; and Dr. E. O. Peterson, Laporte.

DR. JOSEPH COLT BLOODGOOD and DR. CHARLES F. GESCHICKTER, of Baltimore, are presenting a Microscopic, Oral Cavity, and Bone Diagnostic Demonstration, with lantern slides, at the Mayflower Hotel in Washington, D. C., September 17 to 24, 1933. Complete information concerning the demonstration may be had by writing to Dr. Bloodgood, 3301 North Charles Street, Baltimore, Md.

DR. W. D. GATCH, of Indianapolis, was the principal speaker before members of the Carroll County Medical Society at Camden, July fourteenth. His subject was "Abdominal Obstruction." On August eleventh the society met at Rockfield, when Dr. P. E. McCown, of Indianapolis, presented a paper on "Transurethral Treatment of Prostatic Hypertrophy."

DR. E. B. MUMFORD, of Indianapolis, has been made a member of the American Orthopaedic Association. Membership in the association is limited to approximately 135 members in the United States and Canada. Dr. Mumford is vice-president of the Clinical Orthopedic Association and treasurer of the American Academy of Orthopaedic Surgeons.

THE Lincoln National Life Foundation of Fort Wayne has launched a program of research by which it is expected the Foundation will collect, catalogue, and correlate many facts pertaining to

health conservation. The program is under the personal direction of Dr. H. C. McAlister, who has been appointed director of the newly established Life Conservation Division of the Foundation, and Dr. Arthur F. Hall, Jr., who is assistant director.

THE International Assembly of the Inter-State Postgraduate Medical Association of North America will be held in the Public Auditorium, Cleveland, Ohio, October sixteenth to twentieth. A major list of the names of contributors to the programs appear in an advertisement on page xxviii of this JOURNAL. All members of the Indiana State Medical Association are invited to attend. Registration fee of five dollars admits members of the profession in good standing.

THE Eugenics Research Association, Cold Spring Harbor, New York, is offering a prize of $3,000 and another of $1,000 for original research on the inheritance of mental disorders. Only white persons are to be studied, and family history of about 100 years should be considered. Two years will be allowed for the research; typewritten reports are to be submitted to the association on or before July 1, 1935. The announcement emphasizes that the probability of commitment to an institution is the criterion on which the research must hinge. —*J. A. M. A., Aug. 5, 1933.*

In addition to the articles already enumerated the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

E. R. Squibb & Sons

Ipral Tablets, 3/4 grain

The following product has been included in the List of Articles and Brands accepted by the Council but not described in N. N. R. (New and Nonofficial Remedies, 1933, p. 437):

Merck & Co., Inc.

Carbon Tetrachloride-Merck

THE United States Civil Service Commission announces open competitive examinations for medical officer, associate medical officer, and assistant medical officer. Applications for these positions must be on file with the U. S. Civil Service Commission at Washington, D. C., not later than September 28, 1933. Complete information may be obtained from the U. S. Civil Service Board of Examiners at the post office or custom house in any city, or from the U. S. Civil Service Commission, Washington, D. C. Examinations are to fill vacancies occurring in the federal classified service throughout the United States.

THE American Psychiatric Association, at its annual meeting in Boston last May, decided to establish a board to pass on the qualifications of physicians who seek standing as specialists in treatment of mental and nervous diseases. Dr. Clarence O. Cheney, of New York, was made chairman of the board, and other members are Drs. William A. White, Washington, D. C.; Adolf Meyer, Baltimore; F. G. Ebaugh, Denver; and C. M. Campbell, Boston. The purpose of the board is to elevate the standards of qualifications for specialists and to certify those who voluntarily comply with its requirements.

THE United States Civil Service Commission announces open competitive examination for Graduate Nurse, Graduate Nurse (visiting duty) and Nurse, Technician (bacteriology and roentgenology combined). Applications for the positions must be on file with the U. S. Civil Service Commission at Washington, D. C., not later than September 21, 1933. Applicants must have had not less than two years' postgraduate experience in nursing. Full information may be obtained from the Secretary of the United States Civil Service Board of Examiners at the post office or custom house in any city, or from the United States Civil Service Commission at Washington, D. C.

THE Fifth District Medical Society held its second meeting of the year, July twenty-ninth. The meeting was a picnic held in conjunction with the Vigo County Medical Society, on Barbour Hill near Terre Haute. District officers were elected as follows: Dr. W. D. Gerrish, Clinton, president; Dr. J. R. Bloomer, Rockville, vice-president; Dr. James V. Richart, Terre Haute, secretary; Dr. O. O. Alexander, Terre Haute, re-elected councilor for the term beginning January 1, 1934. Following the business session, Drs. O. N. Torian and Louis Segar, of Indianapolis, explained to the societies the new plan of child health work in Indiana. Drs. O. R. Spigler and J. R. Gillum, of Terre Haute, were elected delegates, and Dr. R. G. Harkness and Dr. Alexander Cavins were made alternates to represent Vigo County at the meeting of the State Association in French Lick.

THE thirty-eighth annual convention of the American Academy of Ophthalmology and Otolaryngology will be held in Boston, September sixteenth to twenty-second, with headquarters at the Hotel Statler. Dr. Burt R. Shurly, of Detroit, is president. Major General Robert U. Patterson, surgeon general of the U. S. Army, will be the

academy's guest of honor and will deliver an address on "Progress in Ophthalmology in the Military Service Since Civil War Times." A public meeting has been arranged which will be addressed by Governor Joseph B. Ely, Dr. Edward H. Cary of Dallas, Texas; Dr. Edward Jackson of Denver, Colorado; Dr. W. L. Benedict, of Rochester, Minnesota; and Dr. Wells P. Eagleton, of Newark, N. J.

THE Indiana Tuberculosis Association offers short courses in tuberculosis to the physicians of Indiana. The purpose of the course is to acquaint physicians with recent progress in the treatment of tuberculosis. The work will follow the round table method. Topics constituting the program will be laboratory aids; history, clinical study, and physical examination of patients; treatment; differential diagnosis; childhood tuberculosis; and practical demonstrations. The two day course will be presented at the following institutions on the dates indicated:

Healthwin Sanatorium, South Bend, September twelfth and thirteenth.

Sunnyside Sanatorium, Oaklandon, September eighteenth and nineteenth.

Boehne Tuberculosis Hospital, Evansville, October eleventh, twelfth, and thirteenth. The work at this hospital will be in the nature of ward rounds entirely, the class to be divided into groups and each group to have one day. Those applying for work at this hospital will be notified on which day to appear.

Lake County Tuberculosis Sanatorium, Crown Point, October seventeenth and eighteenth.

State Sanatorium, Rockville, October seventeenth and eighteenth.

Irene Byron Sanatorium, Fort Wayne, October eighteenth and nineteenth.

William Ross Sanatorium, Lafayette, October twenty-fourth and twenty-fifth.

Further information concerning these courses may be obtained by writing to the Indiana Tuberculosis Association, 1220 Meyer-Kiser Bank Building, Indianapolis.

DIFFUSE POLYPOSIS OF THE STOMACH

(Continued from page 428)

CASE II. Mr. E. M., age 60. Entered the hospital complaining of general weakness, loss of appetite, and weight loss. He had always been well and unusually free from any "stomach trouble." About a year ago he began to have some vague epigrastric distress, associated with loss of appetite. This had become progressively worse. He had never vomited prior to his entrance to the hospital. A few times he had observed tarry stools. Physical examination revealed a poorly-nourished man whose skin and mucous membranes showed a definite pallor. The general physical examination revealed nothing of importance. No masses or fluid were found in the abdomen.

The blood count showed a definite secondary anemia; the hemoglobin was 50 per cent; the erythrocyte count was 3.1 million; the leucocyte count was 9,600, with a normal differential. The Wassermann was negative; urine studies were essentially normal; stools showed occult blood. Gastric test meal showed no free acid, a total of 8; blood was present, but no lactic acid was found.

X-ray examination after administration of a barium meal showed several rather large filling defects in the mid-portion of the stomach. Peristalsis was diminished, but the emptying time was normal. These filling defects had all the characteristics of rather large polypi.

During the course of his stay in the hospital the patient had several gastric hemorrhages. Transfusions were of no avail and the patient died. Autopsy was refused.

In the first case, it is probable that one or more of the polypi had undergone malignant degeneration, although no definite roentgenologic evidence of such change could be demonstrated. The rapid downward progress, with death in three months, made it seem probable that malignant change had occurred. In the second case death was due to hemorrhage. The indefinite history in the first case, and the short history of gastric distress in the second, demonstrate the difficulty of clinical diagnosis without adequate roentgen ray examination. The first case is of particular interest because of the presence of polypi in the duodenum as well as in the stomach.

BOOK REVIEWS

BOOKS RECEIVED

ESSENTIALS OF PRESCRIPTION WRITING: By Cary Eggleston, M. D., Assistant Professor of Clinical Medicine, Cornell University Medical College, New York City. Fifth Edition, Revised. 155 pages. Philadelphia and London: W. B. Saunders Company, 1933. Cloth, $1.50 net.

* * *

BOOK REVIEWS

DIET IN SINUS INFECTIONS AND COLDS. By E. V. Ullman, M. D., instructor of the University of Vienna. Recipes and menus, by Elza Mez. 166 pages. Cloth. Price $2.00. The Macmillan Co., New York, 1933.

The author has compiled the most authoritative present day knowledge of "The effect of diet on body chemistry and physiology" and from a practical knowledge has applied it in a most effective manner to diseases of the respiratory tract.

The author clearly states that diet is no panacea in nasal and sinus diseases and susceptibility to them. and will not replace other medical and surgical treatment where indicated, but that by proper attention to basic salts, vitamins, and

minerals in diet selection, resistance to infections is increased and those infections present are easier eliminated. He emphasizes—"Low resistance due to deficiencies" in the diet are results of long standing deficiencies and cannot be corrected in a short time, and warns against expecting too much from concentrated vitamins and other commercial products in a short time.

The average American diet is deficient.

First—Because of our tendency to get away from the fresh natural products. "The process of refining and canning almost invariably reduces the value of food products."

Second—Improper preparation and cooking in the home frequently destroys the chemical and vitamin potency of otherwise good articles of food.

Third—The selection of highly refined and concentrated foods, which can be hurriedly prepared and eaten, are chiefly acid forming, and the acid base foods tend to produce tissue fluid acidity and lowered resistance, while alkalin foods correct the same. Unfortunately many of these premises cannot be corroborated by laboratory experiments, but must be evaluated by clinical observation, which after all is a final test of the efficiency of any therapeutic agent.

The addition of recipes by Elza Mez, for making food palatable without adding too many of the undesirable condiments such as salt, pepper, etc., with suggestions for meals, adds much to the practicability of the book and makes it valuable for the lay public as well as the medical profession.

* * *

REPORT OF THE COMMITTEE ON SURVEY OF MEDICAL SERVICES AND HEALTH AGENCIES. Published by the Michigan State Medical Society. Price $2.50.

This 200-page report, made by a special committee from the Michigan State Medical Society, is to be submitted to their House of Delegates this fall. It represents the investigation made since October, 1931, and is offered with recommendations for a continuation of the work until a solution of the problems involved could be put into operation. Because of the apt phraseology one is tempted to quote too much rather than abstract or paraphrase. The foreword declares that the end of the study was not to be concerned with the means of making more money for physicians. "At no time in the history of the guild have medical men been dedicated as priests to serve at the altar of Mammon. Nor should the objective be merely a struggle for power; rather it should be an attempt to assume intelligent leadership, aiming at a happier, healthier, and more secure social order. The policy of 'laissez-faire,' assuming that change will come of itself and in spite of our efforts, is short-sighted. The profession must concentrate on a study of what seems to be wrong and then try to work out a program of relief. Ever since the English Poor Law of 1601 the right to live has been guaranteed in all civilized countries. The right to live implies more than the mere necessities of life. Adequate medical service must be distributed to the entire population. It would be manifestly unjust to deny any citizen relief from incapacitating illness. To prevent this work from becoming merely another historical excursion into futility, the profession must realize that these labors furnish merely a foundation for further studies. The work must go on until society is relieved from the misery of preventable ill-health, and until there arises an understanding between the profession and the public that will result in a greater mutual respect and security."

The 67 statistical tables and the 36 figures and charts present a wealth of detail and each one has a lesson or bearing on the problem. The first three chapters are of general interest tracing first the evolution of medical care and then following with a well written treatise on the geography, the history and the economics of the wonderful State of Michigan.

Chapter IV on Illness, its incidence, care and costs is abstracted from a larger report made by the Committee on the Costs of Medical Care.

Chapters V and VI on Physicians, their distribution and income. An improved method has been used in determining average incomes and the figures are unusually reliable. "Economically, the average practicing physician's position is not an enviable one. He enters private practice after a large outlay of capital funds at age of 27 or 28; he must make a further outlay for costly equipment; and he must expect to spend 7 or 8 years in gaining the confidence of the community to the end that he may apply himself to practice for a reasonable portion of his time. The wonder is that so few physicians put aside the high code of professional ethics, and collapse under the economic pressure that so many suffer."

Chapters VII and VIII deal with Hospitals. "So great has become the influence of the hospital that often the deciding factor in the location of a physician is its presence or absence in a community. In a real sense the hospital is a public utility and it is apparent that more and more this is becoming the attitude of the public." Attention is called to the lack of uniform accounting by hospital administrators making comparisons almost impossible. The history of the University Hospital is related and the storms centering around full time professors and pay patients are treated at length. "The observation may fairly be made that the hospital and teaching group of the Medical Department of the University has for a long time past met with an antipathy among physicians of the state, which is rather general and in some quarters is most intense." Efforts are being made to correct objections and restrict the use of beds to cases needed for medical education.

The chapter on Public Health shows that Michigan does not differ from her sister states in the multiplication of health officers and organizations. "This can only mean a diffusion of power, a dilution of responsibility, and a loss to the state through failure to realize the full benefits of modern science. It is self-evident that a planned expenditure of the present total could provide much better results than are now realized."

In summary, the problems are better distribution of medical services, especially in rural areas, a more equitable arrangement for the care of the indigent sick and a better coordination of public health activities. The committee approves of the principle of health insurance, but aware of its dangers, insists upon strict and absolute control by the medical profession. It decides that the medical care of indigents is a joint responsibility of the community and the physicians. It recommends subsidizing doctors in sparsely settled localities. The trend of thought is evidently in line with the proponents of the "New Deal" and the committee thinks that if mistakes are to be made they should not be those of omissions. Conservatives will doubtless be offended by some of the ideas but the committee favors the Rooseveltian method of direct attack at present. This study differs from the large report on the cost of medical care in that it was sponsored exclusively by the organized medical profession. The Michigan Committee has evaluated the facts with a fine sympathy for our difficulties and without prejudice or preconceived socialistic notions. For its low cost, a thoughtful student of medical economics can secure in this book a veritable encyclopedia of information. It is of special significance, coming from a state where state medicine has already made such inroads in general practice.

* * *

OBSTETRICS AND GYNECOLOGY: By 80 Leading Specialists. Edited by Arthur Hale Curtis, M. D., Professor and Head of the Department of Obstetrics and Gynecology, Northwestern University Medical School; Chief of the Gynecologic Service, Passavant Memorial Hospital, Chicago, Ill. Complete in 3 Volumes and Separate Desk Index. 3500 pages with 1664 illustrations, many in colors. Philadelphia and London: W. B. Saunders Company, 1933. Per set, Cloth $35.00 net.

Anyone who has read Dr. Curtis's recent small Textbook of Gynecology would look forward with great expectation to a three-volume work on obstetrics and gynecology planned by him. After looking at the first two volumes I believe all high expectations are being realized. The publishers have made attractive books, well printed and beautifully illustrated.

A foreword states that it is to be made up of contributions of a monograph nature by outstanding men of America in obstetrics and gynecology. It is planned to publish a new

edition every five to eight years. One wonders if it would not be desirable in works of this size to make them loose-leaf or to publish a new volume from time to time, rather than to publish complete new editions. It is hoped by the editor that "It should be an inspiration to the specialist, a guide to the independent practitioner, a model for teachers, and a comprehensive texthook for advanced students." It apparently is not just another "textbook" but a comprehensive reference book for the student and the clinician who looks into such a reference book for something other than that which he already knows and all ordinary books reveal.

VOLUME I begins with a complete history of obstetrics and one on gynecology is contained in Volume II. The anatomy of the parts peculiar to this region is written by B. J. Anson of Northwestern University and F. L. Adair of the University of Chicago. The physiology of reproduction is very properly discussed by Emil Novak. The chapters given to embryology are very complete, written by C. G. Hartman, B. M. Patten and L. B. Arey. An important chapter on embryology of the generative tract is by A. K. Koff of Baltimore. The management of normal pregnancy and labor is presented by W. C. Danforth, E. A. Schumann and J. L. Baer in a very comprehensive manner.

There is an extensive chapter on illnesses complicating pregnancy. The final chapters are on the toxemias of pregnancy and premature terminations of pregnancy. There are many shorter chapters on such subjects as sexual intercourse, diagnosis of pregnancy, the newborn child, multiple pregnancy and vitamins in pregnancy.

VOLUME II deals with the pathology of labor and the puerperium including operative obstetrics. Such names as F. B. Falls, E. B. Piper, F. C. Irving, W. E. Caldwell, W. C. Danforth, H. M. Little, N. W. Vanx and H. J. Stander are listed as contributors. The individual opinions and practices of these men make their writings practical and valuable.

The second half of Volume II takes up the infectious processes peculiar to gynecology, with an important chapter on gonorrheal diseases in female children. These chapters are by P. F. Williams, A. H. Curtis, C. H. Norris, G. Gellhorn and N. F. Miller.

The last section, on tumors of the pelvic organs, is contributed by the late W. P. Graves, by K. H. Martzloff, W. P. Healy, E. A. Schumann, J. R. Goodall and R. E. Watkins.

No doubt these volumes portray the best thought and practices of American obstetrics and gynecology of today. One wonders, however, why books of this nature still give space to the consideration of dilatation of the cervix by the Bossi dilator.

* * *

SURGICAL ANATOMY. By C. Latimer Callander, A. B., M. D., F. A. C. S., Assistant Clinical Professor of Surgery and Topographic Anatomy, University of California, Medical School. Foreword by Dean Lewis, M. D. Sc. D., LL. D., F. A. C. S. 1,115 pages with 1,280 illustrations, some in colors. Cloth. Price $12.50. W. B. Saunders Company, Philadelphia and London, 1933.

Doctor Callander has done a momentous piece of work in this book. It represents an enormous amount of work which has been tedious, but which has been done with a thoroughness rarely found in such work. The discussions are clear and concise, but there appears to be nothing left out. His plan of procedure seems very logical. There is a general discussion of the anatomy of a certain part which is well illustrated. This is then followed by a demonstration of its surgical application to this particular part. The surgical cuts are as good as those of the anatomy. The steps in various operations are well shown.

While it is a valuable book for any anatomist or surgeon, it seems well adapted for the beginner who finds it well to review his field of anatomy before beginning any particular operation. It is a good combination of an anatomical and a surgical text-book.

SOCIETIES AND INSTITUTIONS

INDIANA STATE MEDICAL ASSOCIATION
EXECUTIVE COMMITTEE

August 1, 1933.

Meeting called to order at 7:45 p. m.

Roll call showed the following present: W. H. Kennedy, M. D., chairman; H. H. Wheeler, M. D.; J. H. Weinstein, M. D.; O. O. Alexander, M. D.; E. E. Padgett, M. D.; A. F. Weyerbacher, M. D.; Albert Stump, attorney, and T. A. Hendricks, executive secretary.

Members of the Council, Indianapolis Medical Society: R. L. Lochry, M. D., chairman; Dr. Funkhouser; F. J. Hudson, M. D., and Ben B. Moore, M. D.

J. S. McBride, M. D., secretary-treasurer, Indianapolis Medical Society.

Committee on Special Medical Defense Fund: S. P. Hoffmann, M. D., chairman, and W. A. Doeppers, M. D.

The medical defense plan of the Metropolitan Casualty Insurance Company of New York was outlined by J. P. Galloway, M. D., medical director of that company, and Fisk Landers, local agent for the company. Following the presentation of this plan, which was based upon co-operation of the insurance company and the members of the Indiana State Medical Association to cut down the number of malpractice claims, Dr. Weinstein suggested that Dr. Galloway and Mr. Landers present their plan in more detail to Dr. Hoffmann, Dr. Doeppers, and a representative from the local medical society, this committee to report back to the Executive Committee at a future date. The preliminary meeting was then adjourned and the Executive Committee went into regular session, which was attended by the regular and ex-officio members of the Executive Committee.

Minutes of the meeting of June 26 approved.

The bills for July were approved for payment.

The monthly statements of Receipts and Expenditures in June and July and the report of the Budget for June and July for the Association committees and THE JOURNAL were presented.

Notice received from the Indiana National Bank that after June 15 no interest would be allowed on demand deposits. This is in accordance with an inclusive ruling of the Indianapolis Clearing House Association.

Membership Report:

Number of members on July 31, 1933	2546
Number of members on July 31, 1932	2680
Loss over last year	134
Number of members on December 31, 1932	2724

National Recovery Act:

Many letters containing questions as to how the National Recovery Act affects the medical profession were brought to the attention of the Committee. Following some correspondence with Dr. Olin West, of the American Medical Association, the Executive Committee ordered that the following bulletin be sent to the secretaries of the various county societies, the officers and councilors of the Indiana State Medical Association:

"Many letters, telegrams and telephone calls requesting information as to just how the National Recovery Act affects the medical profession have come into the headquarters office within the last few days. These questions have been referred to the American Medical Association and were discussed in detail by the Executive Committee at its regular monthly meeting August first.

"Upon recommendation of the American Medical Association the Executive Committee of the Indiana State Medical Association suggests that no action be taken by the local county medical societies until definite word is received from the American Medical Association in regard to the code and its effect upon the profession. As soon as this information is available it will be forwarded to you immediately. The executive Committee therefore suggests that action be withheld until

further information is received but when this information is received that each member of the profession act in accordance with the suggestions."

1933 Convention, French Lick, September 25, 26 and 27:

(1) Program practically completed. First final draft to be made within a few days.

(2) Letters in regard to accommodations at French Lick Springs Hotel brought to the attention of the Committee.

(3) Report made that Dr. George Dillinger, general chairman, has things well in hand and is planning an unusually attractive program of entertainment.

(4) Three exhibit spaces left. Twelve spaces sold.

(5) Dr. Weinstein is to present certificate of appreciation to Dr. F. S. Crockett, past president, at the banquet.

(6) Upon the suggestion of the chairman of the Committee, the Executive Committee instructed the executive secretary to ask Governor McNutt to be a guest at the annual session of the State Association.

What Is a Clinic?

Dr. O. O. Alexander to prepare material on this subject to be submitted to the editor of THE JOURNAL. Copy of California Clinic law given to Dr. Alexander.

Group Hospitalization:

(1) Article in the August JOURNAL entitled, "What Some Big Insurance Companies Think of Group Hospital Insurance."

(2) Dr. Weinstein and Dr. Padgett reported upon the talk with Harold R. Gordon, executive secretary of the Health and Accident Underwriters Conference, Chicago. (Mr. Gordon is executive head of the organization for more than eighty companies writing this type of insurance.)

(3) Letters from Olin West, M. D., and F. C. Warnshuis, M. D., brought to the attention of the Committee denying newspaper reports that the Michigan State Medical Society had gone on record favoring group hospitalization.

(4) Group medical policy in force at Seattle brought to the attention of the Committee. Dr. Weinstein to make a special study of these policies and report back to the Committee at the next meeting. Request from Dr. R. G. Leland for copies of these policies.

Contract Practice:

(1) Employees Medical Service, Indianapolis. Letter from this group brought to the attention of the Executive Committee. At a called and unofficial meeting of the Executive Committee, held in July, the executive secretary was instructed to make copies of this letter and send them to the secretary of the Indianapolis Medical Society, to the councilor of the Seventh District, and to the officials of the American Medical Association.

(2) Invitation from Dr. Walter Kelly, president of the Indianapolis Medical Society, to the members of the Executive Committee to attend a meeting of the Council of the Indianapolis Medical Society to be held August 3, accepted by the Committee. The Committee was merely to be on hand to listen in at this meeting and not at all to judge whether or not the physicians who have agreed to do this work for the Employees Medical Service are violating the code of ethics. Any judgment in this matter is the duty and prerogative of the local county medical society.

State Fair Exhibit:

Report of the meeting of the State Fair Exhibit Committee held Sunday, July 30, made by the executive secretary. Plans completed for the exhibit which should be very attractive and worthwhile.

Indigent Sick:

(1) First final draft of agreement between State Relief Commission and the representatives of the Executive Committee brought to the attention of the Committee along with letters from Drs. Olin West, W. C. Woodward, R. G. Leland, F. S. Crockett, and J. H. Weinstein.

(2) Newspaper clippings and letters in regard to Lake County, Michigan City and Seymour indigent sick situations brought to the attention of the Committee.

Request to Change Date of 1934 Annual Session:

Letter received from James N. Collins, M. D., secretary of the Indiana Roentgen Society, requesting that the dates of the state meeting be changed as they conflict with the annual dates of the National Roentgen Ray Society. The Executive Committee felt that this was a matter to be taken up by the Council of the Association and hence referred the letter to that body. The secretary was instructed to write to Dr. Collins stating that the matter had been placed on file and would be taken up for consideration for next year's meeting.

Annual Secretaries' Conference, Chicago, September 22 and 23, 1933:

The executive secretary instructed to attend this conference even though he must leave Chicago before the meeting is completed in order to be at French Lick on Sunday morning, September 24, to make arrangements for the state meeting.

Auratone:

An "Auratone Ear Gymnasium" has been established at 701 Guaranty Building, Indianapolis. Reports from otologists state that the method used does no benefit to the patients but actually causes "boilermaker's deafness" in some cases. Report sent to the American Medical Association, the State Board of Medical Registration and Examination, and the Better Business Bureau.

THE JOURNAL:

Letter from Cooperative Medical Advertising Bureau. Letter received from Mr. E. W. Mattson, Manager, Cooperative Medical Advertising Bureau, suggesting that JOURNALS be sent to the homes of physicians in order that the women members of a physician's family may read THE JOURNAL, making THE JOURNAL a more attractive advertising medium for products such as Non-Spi, Cream of Wheat, Shredded Wheat, Sanka, Kaffee Hag, etc. The Committee suggested that a line be added to the 1934 membership receipt blanks asking the physician to state his preference as to whether he wants THE JOURNAL sent to his office or to his home address.

Chesterfield cigarette advertisement in August number of THE JOURNAL. The Committee hopes that the Indiana doctors hereafter will give Chesterfields a break.

Gloss finished paper used in August number of THE JOURNAL. This is getting back to the finish used when THE JOURNAL was published at Fort Wayne.

The Committee ordered the executive secretary to obtain pictures from the members of the Editorial Board for the September issue of THE JOURNAL.

Complaint made that THE JOURNAL of the State Association does not get to certain parts of the state on the first of the month. This matter was to be taken up with the postal authorities and with the printers in order that something may be done to see that hereafter THE JOURNAL gets to the physicians' desks on the first.

INDIANA DIVISION OF PUBLIC HEALTH
BUREAU OF COMMUNICALBE DISEASES

Monthly Report, July, 1933

A marked decline was noted in the incidence of all the principal reportable diseases during the month of July. The noticeable improvement in the number and accuracy of reports submitted is very commendable, and the Bureau appreciates the splendid co-operation of the health officers and physicians. It is only in this manner that we may expect to be admitted to the Morbidity Registration Area of the United States.

A summary of the prevalence of diseases from the urban and rural areas for the month of July is given below:

Diseases	Total	Urban	Rural
Tuberculosis	107	46	61
Chickenpox	24	18	6
Measles	84	59	25
Scarlet Fever	81	62	19
Smallpox	1	0	1
Typhoid Fever	59	23	36
Whooping Cough	203	130	73

Diphtheria	46	19	27
Influenza	49	0	49
Pneumonia	2	0	2
Mumps	7	5	2
Poliomyelitis	1	1	0
Meningitis	8	7	1

DIPHTHERIA. As was expected, considering the season of the year, there was a decrease in the number of cases of this disease. However, it must be kept in mind that such a low record will not remain stable, and that as soon as fall begins the battle will be on again. Why not be prepared: have all school children immunized and preclude any chance of a serious epidemic in your community?

TYPHOID FEVER. The total of fifty-nine cases of typhoid fever during July compares favorably with June when sixty-nine cases were reported. The Bureau has been keeping a vigilant watch on all reports of this disease, and at the invitation of local health officers, Dr. James W. Jackson, State Epidemiologist, conducted extensive investigations in Putnam County, New Bethel, Clinton and Glenns Valley. Reports were written and sent to the health officer, accompanied by recommendations to prevent further spread of the disease in the community. The fifty-nine cases reported occurred in twenty-six different counties, the greatest number from any one county being five from Pike County.

SMALLPOX. July was red letter month for smallpox, with Vanderburgh County reporting the one and only case. This is indeed very encouraging.

INFLUENZA. The records on this disease compare favorably with the total of eighty-one for the preceding month, and fifty-eight for the corresponding month of last year. It is interesting to note that all cases occurred in the rural areas.

Crawford County reported three cases of malaria fever, and one case was reported from Lake County. One case of anthrax in man was reported from the Central State Hospital, the patient having been admitted there from Madison County. The only case of undulant fever reported during the month occurred in Delaware County.

THURMAN B. RICE, M. D.

MINUTES OF THE MEETING OF COORDINATING COMMITTEE OF STATE BOARD OF HEALTH

July 25, 1933

Pursuant to the call of Dr. W. D. Gatch, members of the Coordinating Committee of the State Board of Health met in his office at the Indiana School of Medicine on Tuesday, July 25, 1933, at 4 p. m.: Dr. W. D. Gatch, Supt. Geo. C. Cole, Dr. Jos. E. Weinstein, Dr. O. N. Torian, Mrs. Glen Gifford, Mrs. W. J. Hockett, Peter C. Reilly, Robert E. Cavanaugh, Judge Donald F. Stiver, Dr. John H. Hare, and Dr. V. K. Harvey.

Others attending and participating in the discussions were: Dr. A. M. Mendenhall, Dr. E. E. Padgett, Dr. Thurman B. Rice, Dr. Ernest Rupel, Dr. Clyde G. Culbertson, Eva MacDougall, R. N., Bynum Legg, J. B. Martin, and Frank R. Elliott.

FUNCTIONS OF COMMITTEE REVIEWED

Dr. Gatch reviewed the purpose of the committee, stating that it is purely advisory and educative, having in a sense no actual power, but due to the representative members on the committee it will have great influence in correlating the health activities of the state and might be termed a health council.

One of the chief functions of the committee is to interest the people of the state in public health so that they will be in a receptive mood for the messages of the doctors, thereby bringing together the pupil which is the public and the instructor which is the doctor. The committee will supervise all health activities in the state, arrange exhibits for state and county fairs, and secure publicity for any project through the medical press.

Dr. Gatch stated for the information of the committee that the Bureau of Maternal and Infant Welfare has been abolished by the State Board of Health and the work assigned to the University and the committee.

PLAN FOR MATERNAL WELFARE INSTRUCTION

Dr. Mendenhall presented the following plan for maternal welfare instruction:

1. Each organized county shall be considered as a unit. (83 or 84 in the state.)
2. Information to be furnished the county secretary or his representative in each unit.
3. As it would be very difficult to send information to these units by mail, it would be much better if these secretaries could be called together and detailed explanation given them. It should be impressed upon them that it will be to their own personal advantage to have the laity in their own communities well informed as to better obstetries and better obstetrical care.
4. The State Board of Health should get out pamphlets suggesting what *doctors* could do locally and present them to every physician.
5. The State Board of Health should get out pamphlets for the *laity* on Maternal Welfare; these pamphlets preferably to be distributed by the local medical society to lay women.
6. The State Board of Health should assemble and edit charts, exhibits, graphs, etc., to be loaned to local medical societies for use at lay meetings.
7. Parent-Teacher Associations are probably the best organized of any lay organizations for this purpose and therefore it is very important that they be reached in every community by the local medical society.
8. Occasional larger meetings with speakers from outside when requested by the local organization. As a suggestion, the secretaries of the state could hold an afternoon meeting at which time representatives from the State Board of Health or men capable of giving post-graduate work in obstetrics could meet the doctors of that community. The same evening could be devoted to a mass meeting for the laity as well as physicians at which time subjects bearing on Maternal Welfare could be presented.
9. Continuous effort will be absolutely necessary as it is in common advertising. This message will have to be repeatedly presented to both physicians and laity or the effort will very largely fail.
10. There should be some one connected with the State Board of Health capable of responding to the requests of local units to carry the Maternal Welfare Message to them.

Educate Men and Women on the Importance of Obstetrics

Seventeen to twenty thousand women die annually in the United States of the child-bearing process.

Educate the laity that one-third of these are due to sepsis; one-third to toxemia and that nearly all sepsis deaths and nearly all toxema deaths should be prevented.

This should not be used in the nature of a scare but rather as statistical facts showing what good obstetrics can do.

Educate men to know the importance of the child-bearing process.

Educate women to go early in pregnancy to the doctor. Educate them to select a doctor known to give good care in obstetrical cases and to go regularly to see him.

Educate women as to what good obstetrical care means.

Educate them as to diet, exercise, sleep, rest, and general care.

Educate them as to delivery care and what constitutes good care.

Educate them as to good after care.

Educate them that all pregnant women need good care throughout pregnancy, labor and puerperium.

Educate them that the pure American blood of the better quality is decreasing and that motherhood should be one of woman's greatest hopes and if properly cared for during child-bearing, there should be little to fear.

Dr. Mendenhall's plan was approved and, after some discussion, it was the general opinion of the members of the committee that in cases of emergency upon appeal from the local county medical society, this committee should feel the responsibility of arranging for a speaker on the subject of Maternal Welfare.

Dr. Rice stated that often deaths due to other causes were included in the statistics shown as obstetrical deaths and that if only actual obstetrical deaths were counted the number would not be so great.

Dr. Weinstein moved that each county medical society hold a minimum of one meeting each year for post-graduate work in obstetrics for physicians and a public meeting for instruction of the laity on the subject of Maternal Welfare. Dr. Torian seconded the motion and it was CARRIED.

Dr. Ernest Rupel, Chairman of the Publicity Committee, reported that the pamphlets on file in the office of the State Board of Health have been inspected and those on child health referred to Dr. Torian, prenatal care to Dr. Mendenhall and venereal disease to Dr. Weyerbacher with the request that he formulate some plan for venereal disease control. The advisability of wholesale distribution of pamphlets at the State Fair was questioned. It was thought that distribution by mail would be less expensive than wasted pamphlets.

Mr. Cavanaugh spoke of the visual education service of Indiana University Extension, stating that they have between 1,000 and 1,500 films, many of which are on health subjects, and that he would be glad to incorporate in their next bulletin information in regard to films available from the State Board of Health.

Dr. Gatch asked Mr. Cavanaugh to serve on the Publicity Committee and assist in working out details in regard to visual education publicity. The question of radio publicity was discussed and referred to the Publicity Committee for decision.

Mr. Cavanaugh suggested that the editor of *The Indiana Teacher* be asked for space in that publication for articles from the Indiana Medical Association or from the State Board of Health. Dr. Gatch asked that Mr. Cole and Mr. Cavanaugh confer with the editor of *The Indiana Teacher* and report to Dr. Rupel.

Newspaper publicity as a means of educating the public on the general plan of the Coordinating Committee was discussed. Dr. Rupel felt that through Mr. Hendricks' releases such publicity could be easily handled. Dr. Weinstein suggested that articles appear on the front page if possible. Mr. Elliott stated that the University would cooperate in regard to newspaper publicity.

Dr. Weinstein moved that the Publicity Committee make public the plans for public health under the present set-up of the Board of Health, explaining in detail the cooperation of the University and the State Medical Association with the Board of Health.

Dr. Rice seconded and the motion was CARRIED.

Dr. Harvey explained the nature of the exhibit which will be sponsored by the State Board of Health at the State Fair. Each bureau of the State Board of Health will arrange an exhibit demonstrating the type of work done by that bureau. The State Medical Association, State Dental Society, Nurses' Association and other state health organizations will join in presenting a series of health exhibits.

Dr. Harvey spoke of the playground project which will make it possible for parents to leave children in charge of a nurse at the playground. Mr. Elliott reported that the Indiana University Schools of Medicine, Nursing and Dentistry will present the following health exhibits:

Early diagnosis—booth display and lectures.
Dietetics—exhibit will emphasize correct foods for normal child.
Occupational therapy—booth and movie.
Physiotherapy—state demonstration.
Home Nursing.
Riley Hospital—demonstration of special facilities donated by Rotary, Kiwanis, Psi Iota Psi and other organizations.
Dentistry—dental clinic.
Tularemia.
Gross Anatomy.
Photography in relation to Medicine.
Lectures on diagnosis and other subjects. Cooperation of State Medical Association invited.

Space was offered the Department of Public Instruction for an exhibit of Public Health Work in the schools.

Mr. Elliott stated that the University would loan their State Fair exhibits to county fairs if the county medical association wished to take them over. Dr. Gatch directed that this announcement be given to the press and also suggested that Mr. Hendricks include it in his message to secretaries.

Judge Stiver contemplates the appointment of a county Legion chairman in each county to cooperate with the county medical society rather than a chairman from each Legion post. Judge Stiver was instructed to effect the organization at once and report same to Dr. Rupel when completed in order that publicity be given the American Legion cooperation.

Mrs. Hockett pledged the cooperation of the Parent-Teacher Association as this association is intensely interested in child health and has annually emphasized its "summer round-up."

Mr. Cole spoke of the danger of too great curtailment of the teaching of Physical Education in the schools under present economic conditions and urged that the committee encourage and foster health education in the schools in this present emergency.

Dr. Mendenhall moved and Dr. Rice seconded that the committee go on record as strongly recommending the teaching of physical education and health in the schools. CARRIED.

Miss MacDougall presented the report of the Committee of Nurses which is composed of the following nurses: Nina Douglass, R. N., School Nursing Staff, South Bend; Helen Teal, R. N., Secretary, Indiana State Nurses Association; Lula Cline, R. N., President Indiana State Nurses Association; Eva MacDougall, R. N., Director of Bureau of Public Health Nursing; Matilda Lebline, R. N., Jackson County Public Health Nurse, Seymour; Emma Sater, R. N., Director Public Health Nursing Association, Richmond; Hulda Cron, R. N., Director Public Health Nursing Association, Evansville; Isabelle Devlin, R. N., Director of Allen County Public Health Nursing Service and Ft. Wayne Visiting Nurse League.

QUALIFICATIONS FOR PUBLIC HEALTH NURSES IN INDIANA

Basic qualifications for all public health nurses:
Certificate from 4 year high school (minimum).
Desirable personality and high moral standards.
Registration by Indiana's State Board of Nurse Examiners.
(Graduation from an accredited school for nurses connected with a general hospital having a daily average of 50 patients or more. Curriculum should include practical experience in caring for men, women and children, surgical, obstetrical and pediatric nursing.)

in addition:

(a) Public Health Nurse working alone—
1 year of experience under adequate supervision and four months approved course, or
2 years experience under adequate supervision and six weeks course, or
9 months approved Public Health Nursing Course which includes field practice.

(b) Staff Nurse—
(1) *On a staff with an approved educational program.*
"Fundamental nursing education—
"It is highly desirable in addition, that preference be given the nurse who has had training in communicable diseases (including tuberculosis and venereal diseases); psychiatric diseases and mental hygiene; and such specialties as diseases of the eye, ear, nose and throat; experience in outpatient clinics; and a two months' affiliation with some well organized community health agency."

(2) *On a staff with an approved educational program.*
Same as above plus a 4 months post-graduate course in Public Health Nursing, said course to be one endorsed by N. O. P. H. N.

(c) Supervisor—
At least one year's supervised experience in a well-organized public health nursing agency and a 9 months course in Public Health Nursing endorsed by the N. O. P. H. N.

(d) Educational Director—

"The Educational Director would need all those general qualifications together with advanced academic preparation including educational subjects if possible. It is especially important that in addition to proven teaching ability, she show signs of imagination so that she can fit her individual and group teaching to the immediate needs of her staff and to the broader developments in the community's health program. She, as well as the Director, must have the vision to be a few steps ahead of present practice." N. O. P. H. N.

(e) Director—

The highest standard of qualification should be required of an executive director. She should have more than the minimum education required of her staff. It is desirable that she have an advanced academic preparation, preferably a college degree.

"The Director's experience should include at least two years in a public health nursing service, emphasizing family service. In addition she should have had experience as a supervisor, and when possible, as an assistant executive director. She should have sound administrative ability to organize and direct the work. Such a background would prove her teaching ability, her knowledge of technical skills, and her ability to cope with larger problems of organization and administration. Her distinctive contribution should be the ability to interpret the needs of her organization and of the community to her committee and board members, and to be a leader in community health developments." N. O. P. H. N.

Ways and Means to Interest Communities in Public Health Nursing

(a) Employ no nurse from tax monies unless she meets the minimum qualifications for her position, that is, staff nurse, supervisor or nurse working alone.

(Note: In many instances where Public Health Nursing has failed to meet the approval of medical men and of the community, the nurse has not been qualified. Also, a survey made in 1932 by the State Board of Health shows that the Public Health Nurses, employed by official agencies in Indiana, have lower qualifications than any other group in the state.)

(b) Create a speakers' bureau of qualified public health nurses who can interpret Public Health Nursing to organized medical, dental and local groups.

(c) Adopt a simple explanation of public health nursing and child health as the theme for all publicity.

(d) Consider the sub-committee of public health nurses (serving indirectly through the Committee of the Dean of the University Medical School) as council to the Director of Public Health Nursing of the Division of Health.

(e) Permit the Director of Public Health Nursing, Division of Health, to continue to serve local communities as she has in the past.

Local Program for Child Health

(a) A sound program for child health is based upon a program of family health.

(b) The advice and counsel of the family physician and dentist are requisites of such a program. The primary objectives would be the education of the family to this need.

(c) The public health nurse can be helpful in the crystallization of local thought relative to child health and in the organization of local resources for such a program.

No action was taken on this report.

After some discussion and correction, Dr. Mendenhall moved that the following resolutions which had been drawn up by Doctors Gatch, Rice and Harvey, be accepted and placed on file. Dr. Harvey seconded the motion and it was CARRIED.

RESOLUTIONS CONCERNING PUBLIC HEALTH NURSING

Whereas, The Field of Public Health Nursing in Indiana is in a chaotic condition; and

Whereas, There is no law which prescribes special qualifications for public health nurses, nor any extra-legal standards of qualification which are generally accepted; and

Whereas, There is no legal or other definition of the field of public health nursing in general use in this state; and

Whereas, These nurses are employed by organizations of divers kinds and purposes, and commonly work under no, or inadequate, medical supervision, and often at cross purposes with the medical profession:

Be It Resolved: That the following definitions and recommendations be approved by this body:

First: That the sole professional function of any nurse is to assist the physician in the prevention and treatment of disease. This includes instruction in nursing.

Second: That the function of the Public Health Nurse is to assist the physician in rendering public medical service or public health service, these being defined as follows:

(a) A Public Medical Service is a medical service of any kind rendered to the public by physicians as agents of a public or semi-public organization.

(b) Public Health Service is a special form of public medical service, which has for its purpose the prevention of disease, and which is concerned with the cure of disease only as a means of prevention.

Third: That Medical Social Service should be regarded as a special form of Public Medical Service, and that medical social service workers be physicians or nurses specially trained for this work. Medical Social Service as here used is defined as the rendering of such medical aid or advice to an individual or group of individuals as may enable him or them to make a better adjustment to environment.

Fourth: The Public Health Nurse, no matter by whom employed, should not presume to diagnose disease or to treat disease under any circumstances. For her to do so is to go beyond her province as a nurse, and specifically to violate the Medical Practice Act. When the nurse goes beyond her province in these matters she inevitably incurs the hostility of the physicians of the community and thereby nullifies her usefulness.

Fifth: The Public Health Nurse should be directly responsible to some physician—private, school, institutional, or health—in every one of her duties. The legitimate employment of every Public Health Nurse should presuppose that arrangements have been made for her adequate medical supervision. The employment of a nurse without such adequate medical supervision should be prohibited as a violation of the Medical Practice Act.

Sixth: (a) The Public Health Nurse should have a high school education, be registered in Indiana and in addition should have special training for her work as a Public Health Nurse.

(b) We believe that in addition to adequate training in her profession the Public Health Nurse should possess good moral character, good health, common sense, tact, resourcefulness and adaptability, and that these characteristics may be, and frequently are, more important than professional training alone.

(c) We advise that, pending future developments, no public health nurses be employed in this state till they have been examined and recommended by the Director of the State Division of Public Health and the Director of the Bureau of Public Health Nursing of the State Division of Public Health.

Seventh: We recommend finally that more Public Health Nurses be used, and believe that the most immediate need of the public health in the present emergency is that every community shall have the services of one or more such nurses working under the physicians responsible for the medical and health care of the community.

Dr. Culbertson gave a résumé of the hydrophobia situation and laws pertaining thereto and suggested future legislation. Dr. Hare moved that this committee sponsor the law suggested by Dr. Culbertson and request the Indiana State Medical Association to approve the resolution endorsing the proposed legislation and prepare the act. The motion was seconded and carried.

A discussion of periodic health examinations was postponed.

ADJOURNMENT.

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ORIGINAL ARTICLES

THE WORK OF THE INDIANA STATE MEDICAL ASSOCIATION*

J. H. WEINSTEIN, M. D.
TERRE HAUTE

Because of the depression, the past four years have thrown a great strain upon the profession, and tested the strength of our Association to the utmost, but, instead of weakening, it has been strengthened, and we can look forward with hope and confidence to a stronger, healthier, more efficient organization.

Last year under the guidance of the chief pilot, Dr. Crockett, I served my apprenticeship. The water was rough, the skies were dark, the lightning flashed, and wreck on the shoals of state medicine greatly feared. But your pilot was fearless, expert and efficient; the crew was loyal and could not be stampeded. When time came for me to take the wheel, the storm had not abated, yet there were rifts in the clouds. With words of encouragement and promise of help in emergencies, your old pilot left me in charge. How well I have succeeded is for you to judge. The storm has not abated, but we are still afloat, have not lost any of the crew, and have reason to believe your new pilot, soon to take the wheel, will bring the ship safely into port.

Always in the past the medical profession has raised its own standards, been its own censor, laid down the laws for sanitation and public health, fought the people, fought legislatures, fought the Federal Congress to enforce regulations for health improvement until at the present time we have reached the highest point of longevity, and the lowest point of mortality recorded in the history of man. Yet at this time, at the most glorious period of achievement, outside forces, meddlers, step in and attempt to tell the medical profession what it should do and how it should do it.

Our profession, without aid from laymen, has handed down from generation to generation the practice of medicine improved over what it was when received by it. We of this generation received it in good form. Are we to pass it into the hands of laymen, and have all its traditions and glorious history sunk into oblivion, and the next generation of physicians become the tool of the politician?

If this is to occur, God grant that I may not live long enough to see us, the descendants and disciples of the Great Physician who cured and relieved in his individualistic way, reduced to the necessity of following the trade of practice of medicine as a means of making a living.

The expression so frequently used, the changing times, is true but trite. To remain stationary is stagnation, and stagnation means retrogression. Therefore, we must advance, advance either by known routes or by exploration, either by facts or by experiment, either by knowledge or by trial and error.

Probably today there is more world-wide experimentation in human destiny than ever previously was tried. Through all the ages, through all the changes there apparently remained one great determining factor which survived the tumult, individualism.

I quote the following from the presidential address before this Association in 1912 by Dr. Howatt:

"In recent years a new philosophy of life has been outlined. It has been called the philosophy of change. Every phase of life, every field of endeavor, all sorts and conditions of men seem to have been caught in the tumult of thought and activity. Out of the gruesome conglomeration, however, beams one satisfying, inspiring ray—as the idols have been dethroned and broken, individuality has not been lost. Personal opinion and individual prerogatives have been preserved.

"Independence in thought and individuality in action and belief constitute the foundation on which the superstructure of a free people must be erected. Uniform opinions of the ready-made variety, doled out by the privileged few to the expectant many, have ever been manacles on the intelligence of man."

Without tracing the imperceptible changes in the process, we plunge directly into the declaration by

* Presidential address presented at the French Lick session, September, 1933.

Donald R. Richberg, attorney for the N R A, a man powerful in the councils of the new federal administration:

"The answer to this question is written plain in the universal support of the President's program of economic recovery. There is no choice presented to American business between intelligently planned and controlled industrial operations and a return to the gold plated anarchy that masqueraded as rugged individualism."

Bringing the application down to the medical profession, we find the following statement made by R. L. Duffus: "More extensive medical care we must have; it will be voluntary and co-operative, or it will be bureaucratic. Individualism has had its day."

Along this line of thought, let me remind you of some of the things in the socialist party platform of 1912, or shall I call it liberal party, which seems to be the name of choice today. The progressive party the same year adopted very similar objectives. Those platforms favored:

1. Federal loans to states
2. Public work to relieve unemployment
3. Federal employment bureaus
4. A shorter work day and week to keep pace with production
5. Old age pensions
6. Health insurance
7. Workmen's compensation laws
8. Abolition of child labor
9. Ban on interstate shipment of convict labor
10. Minimum wage laws
11. Graduated income tax
12. High inheritance tax
13. Reforestation
14. Equal suffrage, and
15. Curbing the power to issue labor injunctions.

All the above are accomplished and under federal control except old age pensions, workmen's compensation, and health insurance.

Of the three exceptions, forty-four states have their own workmen's compensation laws, a large number have old age pensions, and a few are toying with health insurance.

In addition to the accomplished objectives above noted, further aims of the liberal have come about, such as "planned economy," federal laws to protect union labor in industry, curbing the financial powers, breaking the power trust, and the placing of liberal leaders like Perkins, Ickes and Richberg, in federal positions of power and trust.

State Medicine

Many of the medical profession are lying back in smug complacency with a sense of security in the thought that there is no danger of state medicine being established.

When you feel inclined to dismiss the possibility of the imminent advent of state medicine, bear in mind that out of the fifteen liberal objectives set forth twenty years ago, two alone remain as unaccomplished on a nation-wide scale, old age pensions and health insurance; and do not be misled into believing that such men as Wilbur, Moore, Filne, et al., have ceased their efforts or are discouraged. The opposition of the American Medical Association has only made them the more determined.

The Committee on the Costs of Medical Care in its majority report proposed many things which appeared Utopian to impractical theorists. Theory and practice go hand in hand, but theory without practice is like the laboratory experiment exploited daily over the radio whereby certain antiseptics are declared to kill germs in ten seconds, and ergo, an aseptic mouth results.

The attempt of a group of theorists, without practical experience, to lay down rules for the practice of medicine, is as ridiculous as for a group of economists without practical experience to lay down rules for the conduct of business—which reminds me of a story told by Dean Kimball of the Engineering School at Cornell University. He said, "Last week I met on the campus one of our professors of economics. I asked him why it was the economists could not compromise like engineers. 'You are divided into two distinct schools, inflationists and anti-inflationists. Why don't you get together and decide the best policies?' 'Kimball,' he said, 'if you took all the economists and laid them end to end, they would never reach a conclusion.'" And Henry Ford has recently said, "I always thought that to manage a business, you should know something about it."

The minority report, prepared by men who combined practice with theory, accepted a few of the suggestions embodied in the majority report, which changing conditions and modern life demand or make practicable. This latter report was acceptable to the American Medical Association and adopted. There has been considerable discussion over two or three of the recommendations in this report. The one that has received the most discussion and criticism in my experience has been number seven, which said, "The minority recommends the development by state or county medical societies of plans for medical care."

The sharpest criticism has been that the A. M. A., to which we all look for leadership, has shown no definite leadership in suggesting a plan which could be adopted, with or without modification, by a large majority of the counties. That the A. M. A. has in its *Journal* printed outlines of plans followed in different localities is admitted, but that it has not given its official stamp to any general plan is the complaint.

With over 3,000 counties in the United States there is a possibility of there being 3,000 and more different plans. Even though each state were to adopt a basic plan such as Indiana has, this still would leave the possibility of forty-eight different plans.

Medical Economics Plans

As has been said concerning our national economic condition, inaction without plans and leadership is worse than action with plans and leadership though wrong. You are at least getting somewhere.

With this thought in mind your Executive Committee decided to adopt as a foundation working basis the so-called French plan. This has been adopted with slight modification in a number of counties. This may not be the right plan, it may not be the ultimate plan, but at any rate the medical profession of the state is getting together and is beginning to think alike about these problems.

By getting the profession to think along the same lines of this economic question, we have been able to control group hospital insurance, corporate practice of medicine, practice of medicine through intermediary agencies, and other movements inimical to the scientific practice of medicine and the welfare of the people.

Not for many years, if ever, has it been the fortune of the medical profession to have a chief executive in our state with the understanding of and sympathy with the medical profession as we have today. Differ as we may with him politically, we can only praise him for his co-operation with the physician in everything medical. While we have not been able at this time to make the director of the governor's relief committee see eye to eye with us, yet the governor himself has stated, it is the wish that all agreements for care of the indigent shall be with the medical society, and not with an individual nor a small group, thereby recognizing qualifications of membership, and allowing the indigent their choice from among these qualified physicians.

There has been considerable fear expressed that an agreement to accept reduced fees for care of the indigent will encourage those able to pay the customary fee to expect the physician to reduce the fee to them also.

I cannot see any valid argument in this line of reasoning.

First. The exhaustive type of service is not anticipated to be given these patients, except in case they are hospitalized, in which event the added expense is paid by the county, city or state.

Second. The patient who expects to pay for his services does not care to be placed in a pauper classification. (You do not find people able to ride in a Pullman sitting all night in a day coach.)

Third. The governor's relief committee has ruled that merchants shall receive but a small profit on goods purchased for poor relief, and the physician accepts the same dictum.

Fourth. We agree to accept reduced fees for cash payment and on what could be called a wholesale basis.

Fifth. We agree to accept reduced fees for work for which we were previously receiving no fees.

Sixth. It re-establishes the personal choice of physician by the patient.

These and many other reasons should dissipate this fear, and make us welcome the opportunity for return of all practice to the individual physician.

Group Hospitalization Plans

Group hospitalization plans have made no headway in Indiana. Extensive investigation and much thought have been given to this question, and your Executive Committee takes the following position on this matter:

We consider it economically unsound. There are insufficient figures to determine actuarially a sound premium sufficiently small to benefit the class of people whom it is intended to benefit, and at the same time accumulate a reserve sufficient to guarantee the policy holders the receipt of services promised. Old established insurance companies will not attempt the coverage of this type of risk, they consider it impossible to pre-determine the amount of hospitalized sick cases, and, therefore, impossible to establish rates or premiums.

It might produce temporarily increased income to the hospital, but within three to five years the demand for hospitalization would be so increased that funds would be exhausted, adequate reserve not having been accumulated, and the hospitals under contract compelled to furnish private and semi-private rooms to policyholders and receive no pay for services. The above reasons need not be added to, to cause one to hesitate before endorsing any such plan no matter how alluring it may appear to the social worker or small income individual.

Intermediary Agencies

The practice of medicine through intermediary agencies has tried to gain a foothold in Indiana, but has not succeeded. The interesting point about the attempts is they occurred in cities wherein are contained state supported schools. One scheme was inaugurated by a university professor, and physicians holding university affiliations became associated with the other organization, although it was inaugurated by a very bright young man whose sole thought was profit for himself at the expense of both doctor and patient.

The entire west coast is honeycombed with sociological schemes of all sorts with competition keen among the groups organized by intermediary agencies. The organized medical profession has organized other groups in self-defense, and the condition of the profession in some localities is quite distressing.

In the east organizations are starting, hospitals are adopting new schemes. Kansas and Nebraska have entered the field. There is no conformity as to plans and a wide observation of the country discloses a most chaotic condition, every community adding some untried theoretical scheme hatched in the brain of a so-called thinker who has had no

practical connection with the practice of medicine, or some one or group whose sole thought is the extraction of profit.

Public Health

Public health is almost the newest branch of medicine. The individual physician in each locality was the original health department, but increasing knowledge of infection, bacteriology, contagion, etc., rapidly brought the necessity of an official health officer with police powers. These things were brought about by the endeavors of the physician. One of our members, speaking before a lay audience twenty-five years ago, said, "The development of hygiene and the prevention of disease is the story of a great warfare waged by a faithful few, often without your aid, sometimes despite your active opposition, against ignorance, vice and ill health. Slowly, silently has the preliminary work of education been carried on until today we have a right, hard won and inalienable, to demand of you that you hold up our hands in our humanitarian efforts."

So successful was the response to this appeal that the public not only held up our hands, but made it an almost complete modern hold-up racket, with gradual usurpation of the practice of medicine by the State Health Department. But this year the practicing physician has been given the opportunity to do his legitimate part in the public health program.

The reorganization and new plans of the State Board of Health will be dealt with fully in a paper presented at this session, so I will touch upon it but briefly. This plan replaces in the hands of the practicing physician the opportunity for each one to practice daily the teaching of public health. It places in the hands of organized medicine the opportunity to guide well meaning lay organizations into the proper endeavors, to discourage unscientific and incorrect activities, and to put a stop to shows and contests put on in the name of health measures, but actually solely for mercenary purposes. If the physicians of the state will assist and co-operate, the State Health Department will be practically only a policing department, that is, it will enforce the health laws, improve sanitary conditions, and make laboratory investigations in cases necessary for protection of public health.

The allied professions, dentists and nurses, have joined us to make a success. Assisting also are the Red Cross, Parent-Teacher Association, American Legion, and other public spirited organizations. The entire plan is one of education, and the Health Department declares its absolute intention of refraining from even the semblance of practice of medicine if the doctors will carry on this plan and co-operate with them and the laymen.

Suggestions

During the acute period of some of our economic problems, it was necessary that special committees be appointed to study the conditions, but it appeals to me now that these questions may well be taken care of by other committees.

I suggest that the Public Relations Committee be enlarged to five or more members, with a view to turning some of this work over to it. All of the following questions are rightfully public relations:

1. Puerperal Mortality.
2. Diphtheria Prevention.
3. Public Health.

I realize this would throw quite an added burden upon one committee, but with an enlarged personnel, the work could be divided among the members. The questions of puerperal mortality and diphtheria prevention are important, but I believe are the province of the newly reorganized Board of Health through its maternity department and child health department, and need only be watched, as should all other questions pertaining to public health, by this committee. Other questions like those above will arise from time to time and if the Public Relations Committee finds its work too arduous, it may ask for help from other members of the Association who may be especially interested in a specific question.

According to the by-laws, the Committee on Medical Education and Hospitals is charged with "providing postgraduate clinics or teaching for the various councilor medical districts"; also it should assume the work of the Committee on Business Instructional Course if anything further is needed. It should also take up the question of high school athletics, as its function could readily be expanded to include not only medical education but all education of the school child affecting in any way his health, or his education on health matters.

The by-laws charge the Committee on Civic and Industrial Relations "to study, gather facts and become intimately acquainted with all and every movement wherever and by whomsoever agitated, proposed or attempted to enact or be enacted, that has as its secret or avowed object the providing of social, commercial or industrial medical insurance for the public, civic or commercial employees of persons or for the providing of medical or surgical care to a group or groups of individuals singly or collectively, or which in any manner affects the economic and financial status of the members of this Association either individually or collectively." It is my opinion that the question of veteran hospitalization belongs to this committee as an economic question affecting the physician. Close contact should be kept on veteran hospitalization, as one may well expect renewed activities when congress convenes. Health insurance is specifically mentioned as a duty of this committee.

The Committees on Lye Burns in Children, Medical Defense, and Medical Registration are special committees to be discontinued upon presentation of their reports. This will leave fourteen committees, exclusive of the Council, which appeals to me as

being sufficient to carry on the work of the Association during the year. If these appointees are carefully chosen, there can be representation on the different committees from practically every county.

Some of the counties elect their delegates every year, thereby frequently having representatives in the house who are unacquainted with routine and cannot successfully represent the county. I feel it will be much more satisfactory to these counties, and will expedite business in the house, if delegates and alternates are elected for two-year periods, and when a delegate is especially interested in organization work, to re-elect him for several terms.

The delegates to the American Medical Association should be members ex officio of the house of delegates. They have never heretofore sat with us, but believing that thereby they can much better represent us at the American Medical Association, I have taken the liberty to invite them to sit with us this year, extending to them the privilege of the floor, but without power to vote.

My attention has been attracted by the number of physicians' names published in newspapers as having talked to civic clubs and lay organizations. Also in radio talks the speaker's name is too frequently mentioned. Even though the talks are sponsored by the local medical society, the Bureau of Publicity ruled in 1929 as follows: The Bureau has adopted a rule that no physician who is in private practice should have his name mentioned in connection with any publicity. The practice of having individual names mentioned in such efforts completely disrupted the Bureau in California several years ago, and was the cause of bitter argument and a split in the St. Louis Society; therefore, the advisability of following the Bureau's rule is heartily endorsed by your officers, and I earnestly request its closer observance in the future.

I take the liberty of quoting again one of our ex-presidents, Dr. Crockett, who said in his presidential address, "Conduct of the medical school and hospitals should be such as to keep the state free from competition with the private practitioner. Considerable irritation has been voiced by certain of our members in the past over regulations which permitted the state, through state owned and operated hospitals, what seemed to be competition with the doctor in private practice. As long as such incidents occur, closer co-operation between the medical school and the State Association will be increasingly difficult. Teaching material only should be admitted to the medical school hospitals. Admission of pay patients places the state in competition with the private practitioners and community hospitals."

Possibilities and Accomplishments

It is a pleasure to be able to announce that there have been removed some of the reasons which called forth the above statement, and there is a warmer, friendlier feeling between the private practitioner and the medical school than previously existed. But much yet remains to be done by the school to gain the entire co-operation of the out-state doctor.

I am given to understand the faculty of the medical school is willing and anxious to accede to the desires of the majority of the profession, but there appear to be certain clauses in the grants to the state and the acceptance by the legislature of these gifts of hospitals which makes it very difficult, if not impossible, to exclude pay and part pay patients.

The possibility of accepting none but teaching patients in these hospitals is being investigated, and I feel quite confident in saying if legally such patients only may be admitted, the faculty will not oppose.

I want to call your attention to two or three things that I think our Association may point to with pride.

Indiana physicians played a most important part in the veteran hospitalization question and were influential in getting the co-operation of the Legion and satisfactory reports by the Shannon Committee in Congress.

Our American Medical Association delegates suggested the possibility of obtaining help from F. E. R. funds to pay physicians, and the American Medical Association was able to obtain a ruling to this effect.

We were the first Association to suggest and obtain a course in business instruction in our medical school. This example was adopted by the trustees of the American Medical Association, and recommended as an addition to the curriculum of medical schools.

The reorganization of the department of public health has created a great deal of interest all over the country, and is being referred to as the Indiana Plan.

Indiana is one of the very few states that has been able to control group hospitalization and group periodic payment plans.

We stand among the leaders of the states having lost the least number of members from the Association.

We publish what we think is the best, and acknowledged by all to be one of the best state journals.

All this and much more has been done without asking for extra money. This has been accomplished by long hours of hard work through the headquarters office. Many economies have been practiced, and, with the same co-operation in the future as in the past, there will be no necessity of any change in our present dues. Organized medicine in Indiana stands at the top. The A. M. A. headquarters has frequently complimented us and holds us in high regard.

So, I say again we can hold up our heads with legitimate pride in our accomplishments, accomplishments not of any individual members, but of

the Association entire, because each officer, each committeeman, each member, felt it his duty and privilege to work and co-operate. Without your help, without your loyalty, your officers could have attained little.

I want to thank the various committees for work well done, willingly, expeditiously, and efficiently.

I expressly want to thank the State Fair Committee which was a last moment appointment. The emergency arose, the committee responded and handled the emergency magnificently.

I also want especially to express my appreciation to some thirty or more physicians who responded on short notice, some by telegraphic notification, and came to Indianapolis from all parts of the state to discuss certain phases of the indigent sick problem.

I want to express my thanks and appreciation to Dr. Dillinger, the chairman, and the entire arrangement committee, also Mr. Fawcett of the French Lick Springs Hotel, for their splendid entertainment and management of this meeting. I know I express the same thought in the minds of your officers and each of your guests.

The past few months have witnessed probably the most trying times in the experience of most of us present today. Still, the troubles we are enduring are usually worse than the troubles through which we have passed. Along with the rest of the country we are threading experiences and experiments new to us all, old or young. Physicians have made little fuss, and have taken it on the chin in a manner proverbial to the medical profession in meeting trouble and solving problems. Your State Association has met these questions, full front, not glorifying in case of victory, not complaining in case of compromise, and standing upright with a smile in case of defeat.

Your new pilot has almost completed his apprenticeship, his skill is demonstrated, and he has instilled confidence in his ability to guide us safely through the continuing storm. My fondest wish for your president-elect is that he may enjoy the same confidence, assistance, and co-operation that you have given me.

ROCKY MOUNTAIN SPOTTED FEVER

(Case Report)

T. Z. BALL, M. D.
CRAWFORDSVILLE

The attention of the medical profession recently has been called to the fact that Rocky Mountain spotted fever is not confined to the Rocky Mountain states, but is prevalent to a greater or less degree in the middle and eastern states; in fact, it is widely disseminated over the entire United States.

On June 7, 1933, I was called to see a patient east of Crawfordsville, in Montgomery County. By occupation the man was a truck gardener and orchardist. When first seen he had a temperature of 104 degrees Fahrenheit, and complained of general aching, headache, and muscular tenderness; pupillary reaction to light was normal; reflexes were normal; throat and chest were negative; there were no respiratory or abdominal symptoms; face was somewhat flushed and sclera was congested; hands were tremulous. His mind was clear, and he provided the information that he was taken sick on May 30th, eight days previously, and that on May 30th he had a very hard chill, which was followed by fever. He had had a number of chills since then and had had fever continuously.

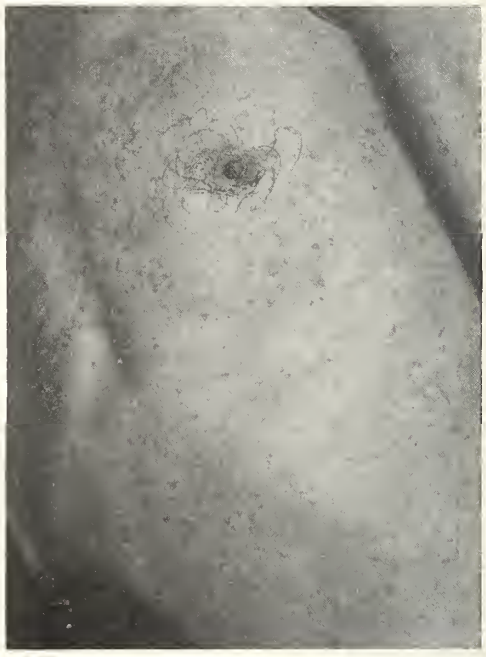


Fig. 1. Photograph of patient showing rash on body.

Examination of the skin disclosed an eruption, petechial in character, uniform, and distributed over the trunk and abdomen. The patient was unaware of the presence of the eruption.

On the following morning, June 8th, the temperature had fallen to 101 degrees, and the skin eruption seemed less prominent and, in fact, had almost disappeared. The afternoon of June 9th, about forty-eight hours after the first examination, I was summoned hastily and found the patient with a temperature of 104 degrees, and the eruption had become more marked, extending to arms, hands, legs, and feet, and to some extent on the face and neck. At this time he was highly nervous and delirious. The patient was removed to the county hospital and placed in a detention ward, and a tentative diagnosis of Rocky Mountain spotted fever was made, after measles, typhus, and epidemic spinal meningitis were ruled out.

The spinal fluid was clear. The hospital was not equipped to do a Weil-Felix agglutination test, and a blood specimen was sent to Washington,

D. C., for the purpose of verifying the diagnosis. A positive report was received within a few days, with the statement that the serum submitted gave complete agglutination of B. proteus X 19 in dilution of 1:1280, and partial agglutination in dilution of 1:2560, and the further statement that this was the first case of what appeared to be Rocky Mountain spotted fever to be reported from Indiana for a good many years.

Only one other case has been reported in Indiana, and that was in Vigo County many years ago. Very few, if any, cases have been reported in surrounding states.

The fever chart beginning on the tenth day of the disease accompanies this report. Photographs of the patient were taken by Dr. V. K. Harvey of the Indiana State Board of Health.

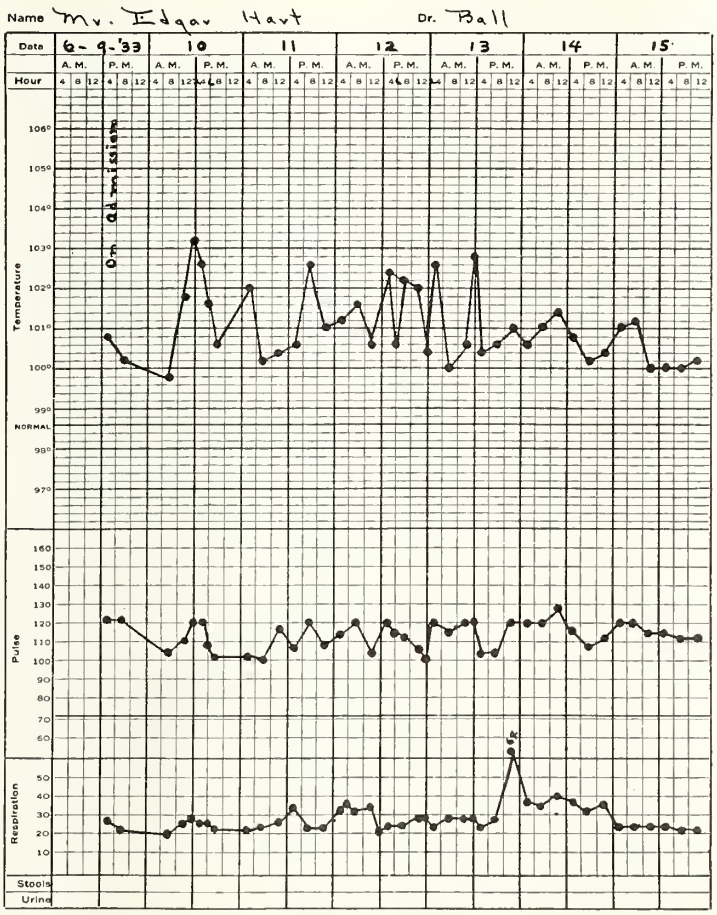


Fig. 2. Temperature, pulse, and respiration chart.

The symptomatology of this case was very much like typhoid fever with the patient becoming delirious on about the tenth day of the disease, remaining in semi-coma until the twenty-eighth day, when defervescence began, and convalescence was definitely established on about the thirty-fourth day. I have no record of the first eight days, but I do know that part of this time he was ambulatory and confined to bed only when the temperature was at its fastigium. He had retention of urine on the fourteenth day, followed by incontinence of urine and feces. The tongue became dry and brown, and he developed decubitus at the tip of the coccyx and at each anterior superior spine of the ilium. There was marked jactation with a low, muttering delirium and subsultus tendinum.

Treatment was altogether symptomatic, with particular attention to feeding and bathing. The bowels, being constipated, were cleansed by enemata. A retention catheter was anchored in the bladder for several days when catheterization was necessary; sodium amytal per rectum seemed useful in quieting the restlessness and delirium. A few hypodermics of morphine were given when the condition demanded.

The patient has made a good recovery, but he recalls very little of his illness. He relates the fact that he removed a wood tick from the back of his neck about two weeks before the date of his illness, and that he spent a great deal of time during the spring picking ticks off of his dogs. Later we obtained a number of ticks from these dogs and sent them to the Public Health Service in Washington, D. C., but unfortunately, with one exception, the ticks died, and that one was found to be not infected.

I am indebted to Dr. Wimple Dodds of the Montgomery County Laboratory for his able assistance in verifying my diagnosis.

TRAFFIC FRACTURE OF THE ELBOW*

M. C. Topping, M. D.
Terre Haute

It has been customary to apply a descriptive terminology to certain types of fractures which we see repeatedly, as the result of the application of the same kind of trauma. We are familiar with "chauffeur's fracture" of the wrist, "teamster's" compression fracture of the vertebrae, and other less well-known injuries which occur as the result of special occupational hazards.

The name "traffic fracture" has been more or

* Presented before the Vigo County Medical Society, May 9, 1933.

less arbitrarily selected to describe a type of injury which has become increasingly prevalent during the past two or three years. It is the result of the foolish tendency of practically all drivers to rest the left elbow on the sill of the car door. This exposes the left elbow to the hazards of traffic proceeding in the opposite direction. Practically all states attempt to regulate the width as well as the length and axle loading of trucks using the public highways; however, there is an increasing

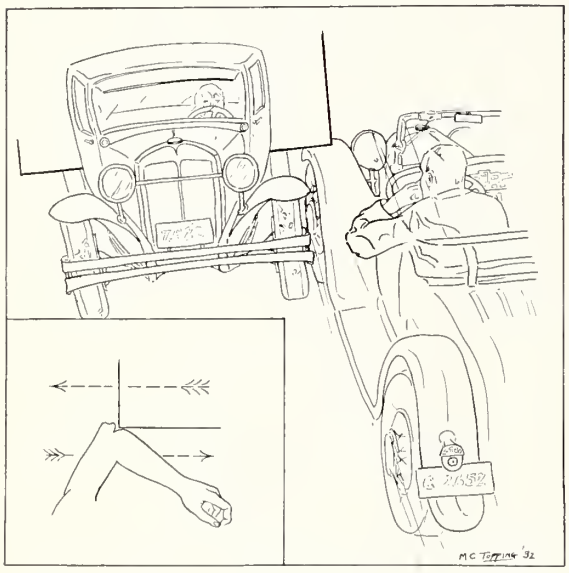


Fig. 1. Diagram showing how impact of truck body against elbow was accomplished.

tendency to build wider truck bodies. These bodies protrude sometimes as much as three feet beyond the confines of the cab and truck bed. It is often not only difficult but impossible for a driver proceeding in the opposite direction to estimate the width of the approaching vehicle, particularly at night and if blinded by glaring headlights. The unconscious tendency to hug the middle of the road makes it possible for the leading edge of these bodies to strike the overhanging forearm without touching any part of the car and without the truck driver's knowledge. The force thus applied, as illustrated, is always to the same part, in the same direction, and produces a characteristic injury.

In such an accident, the patient is conscious of a sudden terrific shock followed immediately by numbness and inability to use the left upper extremity. In five or ten minutes the numbness begins to disappear, and is followed by intense throbbing pain in the whole extremity, particularly severe in the ring and fifth fingers. When first seen, usually one-half to three-quarters of an hour later, the patient is pale, cold, sweating, and nauseated. The pulse is rapid and thready. He supports the left forearm across the abdomen in the palm of the right hand. The thumb and forefinger are approximated, the middle finger is partially extended, and the ring and fifth fingers are flexed. There is a large crescentic laceration across the dorsum of the forearm about two inches distal to the olecranon process, from which oozes dark blood thickly interspersed with fat globules. The forearm and hand are slightly cyanotic, but the radial pulse is readily counted. Palpation of the elbow joint reveals crepitus. Active motion of the hand or fingers may or may not be present.

Roentgenographic examination reveals extensive comminution of the proximal end of the ulna. There is a supra-condylar fracture of the humerus with comminution of the distal end. We usually find some posterior displacement of the fragments, although this is not constant.

Treatment is designed, first, to combat infection; second, to preserve function. Contrary to common orthopedic practice, these two objectives are best attained by sacrificing all of the loose bone. This is accomplished by wide debridement. In attempting to reduce the fracture and conserve the bony structure, we are not only sealing in any possible infection, and furnishing a delightful culture medium in the clotted blood around the fragments, but also we are certain to get an ankylosis, because the integrity of the joint is dissolved. If a careful debridement is performed, conserving the capsule as much as possible, the insertion of the triceps muscle may be confidently sutured to the fascia over the proximal end of the ulna and the wound completely closed except for a Carrel tube. The arm is placed in a Thomas splint with enough traction through the gloved hand to relax the flexor muscles. The wound is irrigated hourly with Dakin's solution. Active motion, of course, is instituted early. The functional recovery of these arms is amazing, and aside from the shortening—which is of no great consequence—the deformity is negligible. In none of our cases was there a permanent nerve injury, although there was a transient ulnar paralysis in one. The circulation was not materially impaired in any, and in our opinion little concern need be felt as the vessels are amply protected on the ventral side of the arm from this type of trauma.

Case Reports

Case I.—Howard D., aged 29 years. On July 17, 1931, about 11:00 p. m., while driving north in Pontiac Coupe, approached a cattle truck proceeding in opposite direction; the body of the truck struck his left elbow, which was resting on the left door of car. Examination revealed the characteristic injury. Debridement was performed with removal of all fragments; insertion of triceps sutured to fascia over proximal end of ulna; wound closed with insertion of two Carrel tubes for instillation of Dakin's solution; anti-tetanus serum, units fifteen hundred, was administered. Recovery was rapid and uneventful. The patient left the hospital walking, with arm in lock-joint brace, on August 5, 1931. Active motion was well instituted

and maximum functional improvement was attained by December 1, 1931.

Case II.—Howard B., aged 24 years. On June 5, 1931, about 9:15 p. m., while driving south on gravel road in model "A" Ford Coach, with road partially obscured by dust, sideswiped approaching truck, injurying left elbow which was resting on left door of car. He lost control of the car, which

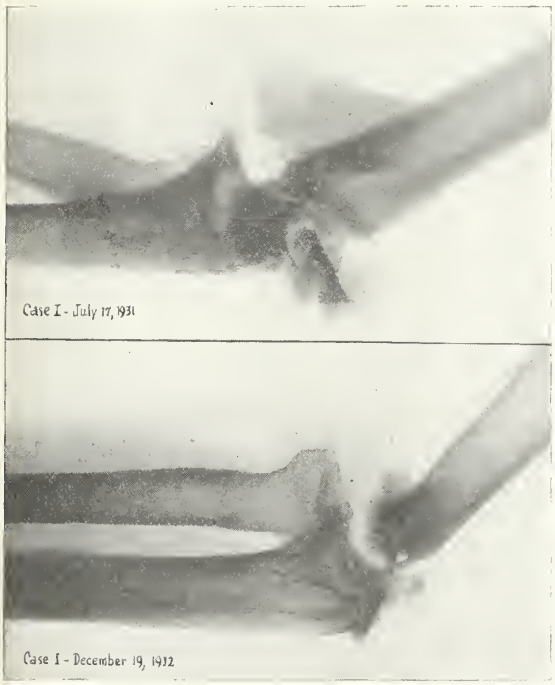


Fig. 2. X-rays of Case I.

was traveling at a high rate of speed, skidded, and turned over onto left side, dragging injured elbow along surface of road for several yards. Examination revealed characteristic injury with additional trauma to the soft parts and contamination of the wounded area with road dirt and gravel. Debridement was performed with removal of all fragments; wound partially closed with insertion of two Carrel tubes for instillation of Dakin's solution; anti-tetanus serum, units fifteen hundred, administered. Within twelve hours there developed a fulminating infection of the forearm necessitating amputation. Patient died on June 7, 1931, of shock following the amputation.

Case III.—Raphael S., aged 32 years. On June 27, 1932, about 8:30 p. m., while driving north on dirt road in Chevrolet Coupe, body of approaching truck struck left elbow, which was protruding from left car window. Examination revealed the characteristic injury. Debridement was performed and Carrel-Dakin's irrigations begun. An uneventfull recovery was made and the patient left the hospital on July 23, 1932. Maximum functional improvement has not yet been attained.

Conclusions: 1. The name "traffic fracture" has been selected as fitting a prevalent injury to the left elbow, the result of the tendency of nearly all drivers to protrude the left elbow from the automobile window.

2. The characteristic injury consists essentially of extensive comminution of the bones about the elbow joint and trauma to the adjacent soft parts. The arterial circulation is rarely if ever impaired.

3. To attain maximum functional return with a minimum of deformity, all bone fragments should be removed and a flail joint created.

THE RECOGNITION OF THE HYPERTHYROID STATE*

R. D. Bayley, M. D., and R. A. Flack, M. D.
Lafayette

The recognition of hyperthyroidism may be very simple, or it may tax the skill of the clinician of wide experience. In this report we have limited our study to those cases observed in our office, and have noted the character and frequency of occurrence of the symptoms in a series of cases in which the diagnosis was later verified by observation following thyroidectomy. The series includes only those cases which were first seen in the office, and upon which a careful history was recorded, and the chief complaint or presenting symptom noted. The cases numbered one hundred and sixty. These chief complaints, where possible, have been grouped under terms which are the equivalent of the words used by the patients themselves, and are enumerated in the order of the frequency of their occurrence.

The most frequent chief complaint was palpitation. It was noted in twenty-seven cases. It may have been only after exertion.

The next most frequent chief complaint was weakness or fatigue. This was usually first noted on going up-stairs. The weakness was most often first noted in the thigh muscles. This symptom was the chief complaint in twenty-four cases.

In twenty-two cases the chief complaint was loss of weight. The amount of weight loss was variable. This symptom assumes importance only in those cases in which there has been no decrease in food intake to account for the weight loss.

Enlargement of the neck was the reason for consulting the physician in nineteen cases.

In fifteen cases the chief complaint was given as nervousness, although attempts were made to elicit a more qualified statement as to the character of the chief symptom. Ordinarily we were able to obtain a more definite statement.

Trembling was given as the chief complaint in twelve cases.

Dyspnea was given as the chief complaint in nine cases.

* Read before the LaPorte County Medical Society, April 20, 1933.

Emotional instability was given as the chief complaint in nine cases.

Rapid pulse was given as the chief complaint in six cases.

Insomnia was given as the chief complaint in only four cases. However, if inquiry was made as to the presence of this symptom, it was found to be present in almost all cases.

Prominence of the eyes was given as the chief complaint in three cases. This, of course, is due in the greater part to the fact that the disease is seen comparatively early. Exophthalmos may be late in making its appearance, and the classification of toxic thyroid states can often be more correctly based upon the presence, or absence, of gastro-intestinal upsets and psychic changes. The pathological classification of diseases of the thyroid, based upon study of the gland tissue removed by operation has undergone revision, in as much as the administration of iodine to the point of full therapeutic effect has altered the microscopical picture of the thyroid tissue.

Ravenous appetite was the chief complaint in three cases.

Precordial pain was the chief complaint in two cases.

A sense of constriction about the neck was the chief complaint in only two cases. This symptom is, however, the most frequent reason for our running a series of basal metabolic tests, usually at the request of the patient.

Tracheal obstruction was the chief complaint in one case.

Nausea was the chief complaint in one case.

Glycosuria was the chief complaint in one case.

In this series of cases we find seventeen different chief complaints, each having been reported by one or more patients as being the most important and most distressing abnormal observation. These symptoms just enumerated include most of the complaints which we have learned to associate with hyperthyroidism, although the relative importance in the mind of the patient, of the different symptoms found grouped together in each case, varies a great deal.

TABLE I.

Types of Thyroid Disease

	Cases	%
1. Diffuse toxic thyroid (Exophthalmic type)	97	60.6
2. Toxic thyroid adenoma	63	39.4
Total	160	

Sex

	Male	%	Female	%
1. Diffuse toxic thyroid	24	24.7	73	75.3
2. Toxic thyroid adenoma	4	6.3	59	93.7

Age

	Max.	Min.	Average
1. Diffuse toxic thyroid	66	14	41
2. Toxic thyroid adenoma	65	19	44

Basal Metabolic Rate (Before Treatment)

	Max.	Min.	Average
1. Diffuse toxic thyroid	PLUS 102%	7%	41%
2. Toxic thyroid adenoma	PLUS 108%	20%	37%

(Toxic adenoma cases showing a BMR of less than plus 20% were not included in this series.)

Over a century has elapsed since hyperthyroidism was first looked upon as a definite clinical syndrome. In 1825 Parry reported eight cases of enlargement of the thyroid gland with exophthalmos and palpitation of the heart. In 1835 Sir Robert Graves reported four cases suffering from palpitation and rapid pulse, nervous symptoms (hysteria), over-prominent eyes and enlargement of the thyroid gland. In 1840 Basedow's first description of this syndrome appeared in the German literature. In 1859 Charcot originated the terms cachexie exophthalmique and goitre exophthalmique. In the early writings on this subject particular stress was attached to four cardinal symptoms, namely, tachycardia, struma (enlargement of the thyroid gland), exophthalmos and tremor. Even prior to these early descriptions of hyperthyroidism, iodine was in use in different parts of Europe in the treatment of bronchocele, as enlargement of the thyroid gland was then termed.

During the last ten years hyperthyroidism has received much more consideration and study than ever before, and we now are learning to associate with this condition many signs and symptoms which were not known to be hyperthyroid in origin. Of all the symptoms of hyperthyroidism, the most constant one is heat intolerance. This symptom was not mentioned in the patient's complaint in any of the cases of our series, but in answer to a direct inquiry almost all of the cases reported its presence. The symptom has been added to our systemic history sheet for that reason. The presence of heat intolerance is often the first definite fact we have, and is more constant in the moderately toxic cases than any other finding. If this symptom is present to the extent that the patient is uncomfortably warm in a house in which the other people do not complain, not even a normal basal metabolic test should be accepted. Quite recently such a case was encountered; there were three normal metabolic rates, and although we did finally show that the rate was high, we would have given up long before had it not been for the presence of heat intolerance and the fact that the skin was too fine in texture for a woman of her age.

The skin, next to heat intolerance, furnishes the most reliable evidence of a hyperthyroid state. The texture of the skin changes to that which one associates with the infant. The skin is not only very soft, but it feels moist without perspiration.

Nausea and vomiting are of particular interest, first, because these symptoms are evidence in favor of the exophthalmic type of hyperthyroidism, and second, because their presence may lead one to suspect some disease of the gastro-intestinal tract. There may be frank pain which has been mistaken for acute appendicitis. These symptoms may constitute a real danger to the patient, for surgery

may prove disastrous. Periods of diarrhea, unexplained by any demonstrable gastro-intestinal pathology, are not infrequently observed in cases of the exophthalmic type.

The question of loss of weight is an important one. It should be ascertained, if possible, approximately how much food has been taken. There is occasionally some loss of appetite with the nausea of the early exophthalmic type, but loss of weight, despite the fact that the patient eats more than anyone else in the family, is the rule.

A rapid pulse is, of course, the usual finding in this disease, but the fact that the greater number of people who think they have thyroid disease are also apt to have a rapid pulse under the circumstances of a first visit to a doctor makes it a less valuable sign. A fair percentage of those who come to us under those conditions have neurocirculatory asthenia. They have a rapid pulse when they are up and about. It is also fast when standing, or sitting, but the rate slows very quickly on lying down. On the other hand, a number of days instead of a number of seconds are required for the pulse rate of the hyperthyroid to settle down to the same degree.

The difference between the systolic and diastolic blood-pressure is, in hyperthyroidism, greater than the usual third of the systolic pressure. This is probably due to the increased blood flow through the peripheral vessels. The change is accompanied by a fall in the diastolic pressure.

Auricular fibrillation is very frequently associated with hyperthyroidism, and every case of this type of arrhythmia should be considered as a possible hyperthyroid until the cause is known. Auricular fibrillation is, in almost all cases, associated with mitral stenosis, hypertensive heart disease, or hyperthyroidism, and in cases in which signs of mitral stenosis, or hypertensive heart disease, are absent, hyperthyroidism is almost a certainty. The fibrillation may be of the paroxysmal type. In the presence of hyperthyroidism this arrhythmia responds very poorly, if at all, to digitalis therapy, and such an observation should call for a careful search for other signs of thyroid disease.

Two months ago we observed a case which illustrates this type of thyroid-heart condition. A widow 67 years of age had been in bed for five weeks under the care of her family physician. She had had a cancer of the breast removed in 1929, but had been otherwise well until two years ago when she began having some rapid palpitation and fatigability. She had lost weight from 100 to 85 pounds. During her period of bed rest digitalis, large doses of bromides, small doses of thyroid extract, and finally hypodermics of morphine two and three times a day had failed to give the patient rest, and had failed to slow the rapid heart. She had been eating rather poorly, had been vomiting one or more times daily, had been very nervous, and had slept poorly. On examination the heart was found to be fibrillating 150 per minute. There was a finger tremor. The skin was soft and moist. The patient admitted a moderate, but definite, heat intolerance. A tentative diagnosis of hyperthyroidism was made and Lugol's solution was prescribed. The patient noted definite improvement within 48 hours, the vomiting ceased, the patient began to rest well at night, and the appetite improved. The heart rate slowed promptly and within a week had returned to sinus rhythm. One week ago we had the opportunity of seeing this patient again. The heart was regular and less than 90 per minute. Her weight had increased from 85 to 92 pounds. She had been up and about part of the time since the first three weeks of iodine therapy. Iodine had been stopped as the patient did not wish to enter the hospital until the latter part of this month. Iodine will again be used when the patient enters the hospital for thyroidectomy. Because of this patient's age and because of the state of nutrition we prefer a longer period of iodinization prior to operation.

A sign of real importance, when it can be found, is the bruit heard over the upper poles of the thyroid gland. The murmur is usually present with systole, but may be heard throughout the heart cycle. In listening for this murmur, it is necessary to use only the slightest pressure.

Another rather interesting finding is the redness of the skin over the olecranon process of each elbow. This is very constantly observed in those patients who have been kept in bed and who, because of marked restlessness, have been turning, or raising up in bed, many times each day.

Glycosuria is a finding which sometimes leads to an erroneous diagnosis of diabetes mellitus. The amount of sugar excreted in the urine in such instances does not bear a direct relationship to the carbohydrate intake. The fasting blood-sugar is found to be within normal limits, and glucose tolerance tests do not show any delay in glycogen storage. The degree of glycosuria is never great enough to account for the incapacity of the patient, nor for the weight loss. Insulin does not clear the urine of the small amount of sugar, as one would expect.

A change in the temperament of the hyperthyroid is very frequently observed. It may occur as the first symptom; it is more frequently admitted if inquired for; and is often present even after surgery has relieved the accompanying symptoms, in which case the prescribing of small doses of Lugol's solution often affords relief to the patient and to the relatives.

Frank psychosis is not uncommonly observed in the hospital. One patient in this series came to the office while on leave from a hospital for the insane. This woman had been committed because she had made life unbearable for her family. On one occasion we observed a patient who had driven her daughters from the home in the dead of winter. She was subject to such fits of temper until re-

lieved by thyroidectomy. The observation of a few such cases causes us to wonder how many cases of psychosis due to hyperthyroidism have, in the past, failed to receive proper recognition. No doubt a certain number have been committed as insane, thereby attaching a certain stigma to the family and usually depriving the patient of the proper treatment. One can readily imagine the resentment toward the physician arising in the mind of the patient and in the minds of members of the family, after the patient, who was considered incurably insane, has been treated elsewhere and has recovered following thyroidectomy. The possibilities of medicolegal entanglements in such instances are ominous.

In the diagnosis of hyperthyroidism the determination of the basal metabolic rate is, at times, a great aid. One must, however, take into consideration the fact that the metabolic rate which you obtain may not be a basal metabolic rate. The patient may have the idea that the technician is going to smother her, or anaesthetize her, or she may be so nervous that it is only with great effort that she can keep still. It is usual for the first test to be high, and this is usually due to the fact that, during the test, the inability to breathe in the ordinary way frightens the patient. For this reason we do not rely upon the first few rates. We consider them as trials before the tests which can be made when the patient is at perfect rest. The failure to use the basal metabolism test in this way leads to more error than fact. In the severe type of hyperthyroidism, a basal metabolic test is unnecessary for diagnosis, although it is gratifying to see one which supports your clinical opinion, and in the milder type and the border-line cases caution must be used. Not many years ago we frequently noted the amount of improvement of our cases during the period of medical treatment in the hospital preparatory to thyroidectomy, by the running of repeated tests. This, no doubt, gave us valuable information with which we might judge future cases, but it was disturbing to the patient.

If a diagnosis of hyperthyroidism cannot be definitely proven, or disproven, by clinical or laboratory means, iodine may be used as a therapeutic test. If the tremor begins to quiet down after a few days treatment with Lugol's solution; if the patient begins to get some sleep without hypnotics; and if the patient states that he feels at ease for the first time in months, we may feel certain that the change is due to the effect of the iodine upon the hyperthyroid state. In the use of this test, the clinician can assure himself that he is administering sufficiently large doses of Lugol's solution to obtain a reliable opinion from the test by using the drug in the same dosage as would be used to prepare the patient for thyroidectomy, if the diagnosis had been definitely established and thyroidectomy decided upon. However, the use of this test is not without certain real dangers to the patient and distinct disadvantages to the physician. In our experience we have used this test to great advantage from the diagnostic standpoint, in a number of rather puzzling cases, but we are becoming more and more prejudiced against the use of the test. Although the patients are invariably informed prior to the starting of the iodine that, if improvement ensues, surgery will have to be submitted to, the hyperthyroid who responds to the test often feels such marked improvement that he will turn a deaf ear to any advice in regard to surgery, or to the subsequent progress of his condition if he fails to follow directions. It is hard to sell surgery to a hyperthyroid who, after a few days medical treatment, feels better than he has for months. The doctor loses control of the patient, at least for a period of time, and when the condition must be dealt with later on, the problem is decidedly much more serious. We have felt that certain patients of the more intelligent class could be excepted, but we are coming more and more to the conclusion that the large percentage of cases get out of control following a favorable response to this test.

Lastly, in the absence of definite knowledge, we are entitled to an opinion as to the cause of this variable clinical syndrome. We have noticed that the condition has frequently followed some acute infection. Several cases have been observed following acute throat infections. One case followed an acute cholecystitis. The pathologist repeatedly reports some inflammatory change in the thyroid tissue removed at thyroidectomy.

Another circumstance which has frequently immediately preceded the onset of symptoms is a psychic insult, usually some fright. These circumstances have many times been cited by the patients in dating the onset of the symptoms. In one case the person narrowly escaped being struck by lightning. In another instance an electrician, who was accustomed to trying out 110 volt lines with his fingers, was momentarily frightened and could not throw off the idea that he might have been in contact with a line of much higher voltage. He developed exophthalmos in a few days time. One of the cases dated the onset of symptoms from a burglary in her home. Another case, a physician's wife, was frightened by a window being broken close to her ear. She afterward was the first to recognize the disease in her husband, when it came on following an acute hemolytic streptococcic infection of the throat, the only instance in which we have seen the disease in both husband and wife. Recently we saw a railway brakeman who developed symptoms after falling between two freight cars, although he suffered only minor injuries. Most, if not all, of these cases developed symptoms of the exophthalmic type of goitre.

The question often arises whether or not hyperthyroidism is ever present when the metabolic rate is normal. There is considerable controversy in this regard, and the view that Grave's disease is dependent primarily upon a state of imbalance of

the autonomic nervous system, and secondarily upon thyroid hypersecretion is being held by many clinicians. This view may offer some explanation for the persistence after thyroidectomy of exophthalmos, nervousness, palpitation and fatigability in some cases in which the basal metabolic rate has returned to normal, or may have actually dropped below normal. Until recently the term Grave's disease has been restricted to those cases having hyperthyroidism, and the two terms have been looked upon as synonymous. More and more the term Grave's syndrome has been applied to that large neurogenic group of cases, which may or may not develop true hyperthyroidism following the occurrence of some psychic insult. Failure to differentiate between the true thyroid syndrome and that of neurogenic origin is in great part due to the fact that many practitioners seem to under estimate the part played by the functional nervous system as a cause of many varied symptom complexes.

In conclusion, it becomes apparent that hyperthyroidism for the most part is a well-defined, yet often not easily diagnosed, symptom complex. The most dependable symptoms we have are (1) definite loss of weight in the presence of a normal, or increased, food intake; (2) a persistent tachycardia over 80 per minute; and (3) a constant feeling of warmth, or of heat intolerance.

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MEDICAL CARE OF THE INDIGENT IN INDIANA

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This article concerning care of the indigent sick should be of some interest to members of the Indiana State Medical Association because it is based on an analysis of questionnaires sent to every county society secretary in the state and to a few other physicians suggested as references by their respective secretaries. Absolute accuracy is not claimed, for changes occur frequently and several questionnaires were returned with a note that the society was striving for a better plan at that time.

Evaluation of the data secured can be facilitated by a perusal of the questionnaire itself. Stripped of the explanatory matter which accompanied it, it reads as follows:

1. In your county is there any provision for care of the indigent sick in addition to, or in place of, the township trustee? 2. (a) If No. 1 is answered in the negative, how does the trustee handle the situation, i. e., by contract with one or more physicians or by paying a fee for each case to private physicians? (b) If using the individual fee system, approximately what percentage of the regular fee is paid? 3. If No. 1 is answered in the affirmative, what method is in use for care of the indigent sick in your county (or will be in use in the near future)? 4. If your county society has a contract with the trustee(s) or Board of Commissioners, what method of payment is used: (a) Lump sum? (b) A percentage of total expenditure for poor relief? If so, what percentage? (c) How is the money divided among the doctors? 5. Does your plan affect the charity service of your local hospitals? If so, in what way? 6. If you are using a contract or similar method for handling this problem, how long has it been in effect? How well do the doctors like it? How well do the indigent sick like it? Are the county and township authorities satisfied? 7. Have you had to make any changes in your original plan? If so, along what lines? This questionnaire has been approved by Dr. J. M. Fleming of Elkhart, chairman of the Special Committee on Medical Care of the Indigent of the Indiana State Medical Association.

Interest in this problem was high enough to secure answers from all but ten of the secretaries, and as questionnaires are pesky things at best, I take this occasion to thank the seventy-two who supplied the data.

When all the returns were in, the number of permutations and combinations was found to be so formidable that an outline map was decided upon as the best medium for graphic presentation of the results, and all the statistical data are on the map or in the legend.

Many interesting points, however, must necessarily be commented upon without diagrams and curves. For instance, the map has nothing to say, except by implication, concerning the ever-present bugbear and stumbling block mentioned so many times in marginal notes or in other asides—namely, that great octopus *politics*. It is to be hoped that such tentacles will soon be removed from the feet of Aesculapius by the very nature of the problem.

In some counties the lack of uniformity in different townships or cities is confusing to the outsider, but at least it shows the different localities are doing the best they can according to circumstances of politics and practical expediency. Such an one is Elkhart County, where the Goshen Medical Society has a contract with the trustee for a lump sum, while the Elkhart Academy of Medicine has a similar arrangement, but contemplates a change to a straight fee basis at a reduced rate, allowing the patient to choose his own physician. Another is St. Joseph County, which is mapped as using "contract doctors." While this is true in Porter Township (South Bend), it is hardly fair to the Mishawaka Physicians' Club to omit reference to the work accomplished in Penn Township, where the indigent are cared for on a very reduced fee schedule, but are allowed their own choice of physician. For the first quarter of 1933 the indigent sick expense in Penn Township amounted to 6.5 per cent of the total indigent re-

lief, including doctors, hospitals, drug stores and dental care.

Madison County has three different systems in vogue in the several townships: a plan including all physicians in Anderson Township who wish to join; "contract doctors" in two other townships; and in the rest the individual fee system.

Some counties have fees for surgery (and sometimes obstetrics) in indigent cases lower in proportion than for other work—to mention a few: Carroll, Gibson, LaPorte, Randolph, Wabash, Kosciusko, Fulton, Clay. A few counties have "contract doctors" for medical work, but use the individual fee system for surgery. (In this connection one refrains with difficulty from toying with the notion that perhaps inefficiency is harder to disguise in the case of the surgeon.)

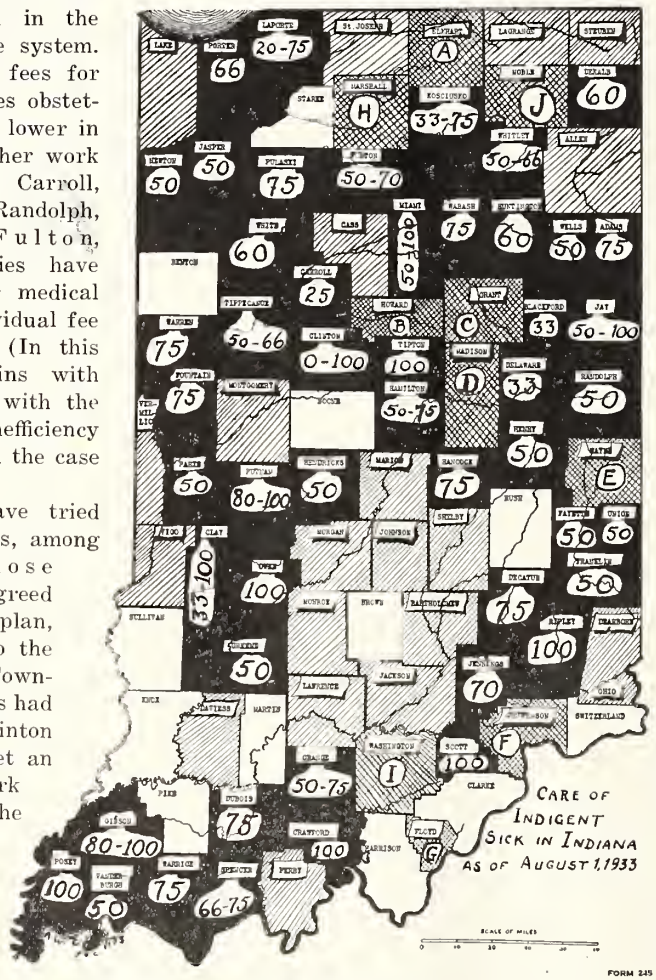
Several counties have tried to improve their status, among them Tippecanoe, whose medical society has agreed to offer the Kokomo plan, with slight changes, to the trustees. Fairfield Township, in this county, has had a "contract doctor." Clinton County is trying to get an agreement to do the work for 6 per cent of the total indigent relief. In Vigo County a proposal made by the medical society along similar lines was ignored. The Hamilton County Society has recently studied their situation and the committee recommended an agreement with the trustees, using the unit system of accounting, but the final result of their endeavors was not reported. Lake County has had its troubles, with the civil authorities paying no attention to suggestions and offers made by members of the county medical society.

Among the counties successful in securing an agreement between the medical society, or its members, and the civil authorities, several are of special interest. In Noble County there is a verbal agreement between all the doctors and all the trustees. The plans of Howard County and Grant County have been presented in detail in THE JOURNAL for April and May, 1933.

Experience seems to favor plans based on some agreed percentage of total expenditure for poor relief, or upon a system of individual fees rather than upon a lump sum covering a stipulated period of time. A good example of how the latter works out is New Albany Township in Floyd County, where under a contract for a fixed sum, prorated among the doctors, only 16 cents was realized on each dollar's worth of work done. This seems a little unreasonable, even in times like these.

While the map is fairly accurate as a whole, some counties shown in black do not employ payment on an individual fee basis in every township. *Of the counties marked black*, those having a "contract doctor" in at least one township are as follows: Hamilton, Wabash, Tippecanoe, Henry, Orange, Fountain-Warren, Spencer, Putnam, Jay, Owen.

In a few counties, listed otherwise on the map, there is an agreement between the organized physicians and the civil



Solid black: Paid by trustee on individual fee basis. Figures indicate approximate percentage of regular fee paid.
Diagonal lines: Contract between trustee and one (or a few) physicians (usually on salary) in many, if not all townships, or involving a large population. No sanction by medical society.
Criss-cross lines: Agreement county medical society (or a large percentage of its members) with trustees and/or commissioners. Letters refer to legend given below.
Plain white space: Questionnaire not answered.

A. Elkhart County—Elkhart Academy of Medicine and Goshen Medical Society each have contract with trustee for a stipulated lump sum. B. Howard County—"Kokomo plan"—doctors receive 6 per cent of total expenditure for poor relief. Each patient has his own doctor. C. Grant County—Agreement between Governor's Committee, county commissioners, and members of the county medical society. Patient allowed choice of physician. D. Madison County—Agreement in Anderson Township only. Physicians give dispensary service gratis, but are paid for other work. Mixed methods in other townships. E. Wayne County—In Wayne Township (Richmond) a lump sum prorated among doctors. Patients have own physician. F. Jefferson County—Written agreement between trustees and practically all physicians: fee for each case at 85 per cent regular charge. G. Floyd County—Contract between trustee and county medical society for lump sum, which is prorated among doctors. (First quarter of 1933 they realized 16 cents on the dollar of actual work done.) H. Marshall County—About two-thirds of physicians in county have signed contract (covering nearly all the indigent work) to work on basis of 50 per cent of regular fees; may soon be reduced to 40 per cent. I. Washington County—Agreement between county society, trustees, and county commissioners; fee paid for each case at 80 per cent usual rate. J. Noble County—Verbal agreement between county society and trustees: fee paid for each case at 66 per cent of usual rate.

authorities in at least one township, although the great majority of townships are under other systems. Such counties are: Clinton, Hendricks, and St. Joseph.

As far as the hospitals are concerned none of the plans seem to affect them. In a few instances mention was made of certain rates paid the hospitals by the trustee, but this seems to be a separate agreement entirely apart from that with the physicians. As for the remaining items in the questionnaire the number of answers received was not sufficient to make any comment.

If any conclusion can be drawn from the material in this survey, it is a rather sad commentary upon the attitude of the public toward the profession in this particular field. The corollary to this is that the profession itself has not done all that could be done about it. Common sense prompts us to inquire: with only slight variations over the state in fees usually charged to private patients, why should medical care of the indigent be worth all the way from zero to one hundred per cent of the usual charge in different townships of the same county, and why should there be similar differences between counties in the same state? The same common sense, finding no answer to these questions, then asks: Why should there not be a uniform plan for medical and surgical care of the indigent for the entire State of Indiana with the least possible variation to suit local problems? And finally, if such a plan is worked out, acceptable to the Governor, the Indiana State Medical Association, and the Reconstruction Finance Corporation, will every member of every county medical society support it wholeheartedly? If he can see beyond his nose, *he will.*

INDICATIONS FOR SURGERY IN GALL-BLADDER DISEASES

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A great deal of progress has been made in our knowledge of gall-bladder diseases since the first cholecystotomy was performed by Dr. John S. Bobbs in Indianapolis in 1868. This progress has been marked in recent years by an intensive study of the physiological function of the gall-bladder, a mastery of the surgical problems involved, and methods of great accuracy in diagnosis. During the last fifteen years probably no other medical subject has received more intensive study, from the viewpoint of function, diagnosis, and treatment, than has the gall-bladder.

It is recognized that standardized rules of procedure cannot be formulated for the treatment of individual cases of gall-bladder disease. However, there are certain facts which emerge in the study of large groups of cases which when analyzed aid in the solution of individual problems.

On advising patients with gall-bladder disease relative to operation, certain very pertinent questions arise which may be conveniently discussed under the following heads:

I. Risks of operation.
II. Probability of complete recovery, if operated.
III. Hazards to life and health if operation is not done.

I. It is necessary in discussing the risks of gall-bladder surgery to call attention to certain factors which have a bearing on the question of operative risk and which are peculiar to this type of surgery. The character of the pathology present may be such as to definitely increase the risk. The assaults of long standing and repeated acute infections leave their mark in inflammatory adhesions of neighboring viscerae, in contracted fibrotic and functionless gall-bladders filled with stones, in gangrenous and ruptured gall-bladders, in fact, every conceivable deformity of a normal vesicle may be found as a result of the devastating effects of long standing infections.

Two factors are involved in gall-bladder pathology; stones and infections. While perhaps closely related as to etiology, each plays a distinct role as to symptoms and the ultimate outcome of the disease. However silent a stone may be when resting in the gall-bladder, its impaction in the common duct adds greatly to the operative risk. Lahey reports a mortality of 13.3% in common duct stones compared with 2.2% in cases not having common duct stones. Circulatory disturbances plus infection may result in thrombosis of the cystic artery with resulting gangrene of the fundus of the gall-bladder followed by perforation, the same sequence which we see in the appendix.

When we consider these serious lesions of the gall-bladder and the intimate anatomic relation to such important organs as the liver, pancreas, duodenum, common bile duct, hepatic artery, and portal vein, it is easy to understand the difficulties of the surgical problems involved.

Another factor which influences operative risk has reference to the personal equation of the surgeon who undertakes to do gall-bladder surgery. That this is a large factor is shown by the wide range of mortality rates published by various hospitals. High mortality rates were undoubtedly caused by the fact that when the surgical dictum, "Cholecystectomy is the operation of choice" was broadcast over the country from our highly developed surgical centers, it caught the surgical profession as a whole unprepared to meet the grave responsibilities of this type of surgery. Fortunately, this era has largely passed, and surgeons now generally recognize the great technical difficulties and the necessity of sound surgical judgment in dealing with surgery of the gall-bladder.

In this connection the statement of Sir Berkley Moynihan will meet with universal agreement: "The surgery of cholelithiasis is difficult, sometimes extremely difficult. I hold it to be of greater tech-

nical difficulty and to present more problems for immediate accurate judgment than any other branch of surgery. If I might presume to offer any advice to the surgeon who has not great and continued opportunities for practical work, I would suggest to him never to do gastroenterostomy in the absence of a demonstrable lesion which requires it and to leave the surgery of the gall-bladder alone."

Mortality rates during recent years have steadily declined so that in the hands of experienced surgeons, and under proper preoperative medical management, excluding the more serious cases of perforation and common duct stones, the mortality is below 3%. Equal credit for this reduction in mortality rates is due to the greatly improved preoperative medical management. Impaired liver and kidney function, cardiac and vascular degenerative lesions and metabolic disturbances may be present and require careful attention.

II. What are the probabilities of complete recovery to normal health and freedom from symptoms in a patient operated upon for gall-bladder disease? The answer to this query is of first importance, for any therapeutic measure must justify itself solely upon results. Recognizing the necessity of a check on end results, many of the larger clinics have made a follow-up study of gall-bladder cases, reports of which may be found in the literature. The results of these follow-up studies have been illuminating. They show that certain types of gall-bladder disease, when treated surgically, are cured of their symptoms and return to normal health, while another group is frequently not cured and continues to suffer from the same symptoms after the gall-bladder has been drained or removed.

In a study of any series of follow-up cases, it will be found that the percentage of complete cures will bear a direct ratio to the number of cases in that series which were suffering from the presence of calculi in the gall-bladder or extra-biliary ducts. That is to say that if the surgeon operates on a relatively large number of non-calculus gall-bladders, the percentage of cures will be correspondingly less. This fact is illustrated by comparison of end results found in a series of 100 cases operated at the Robert W. Long Hospital with a series reported by Deaver and Bortz in which 84% of the Long cases were calculus gall-bladders with 79% cured, while in the Deaver series only 53% of cases had calculi, with 64% cured. The same story is told in our series wherein it is found that in the calculus group 84% were cured as against 72% in the non-calculus group. These findings are typical of all the follow-up studies appearing in the literature, and show distinctly that the prognosis for complete relief from symptoms in non-calculus gall-bladder disease when operated is less favorable than where stones are present. It follows, therefore, that when advising patients as to operation, caution should be observed in prognosis unless the infected gall-bladder or ducts contain stones.

III. What hazards to health and life must a patient with known gall-bladder disease assume, if he refuses operation? Is it better for him to bear his ills, than fly to others he knows not of? The impairment to health may be negligible, consisting of a persistent dyspepsia with inability to digest certain kinds of food. At the other extreme, complications may arise which result in grave dangers to life. Stones may be impacted in the cystic duct, which when associated with an active infection may result in empyema of the gall-bladder, gangrene and perforation. Repeated attacks of gall-bladder infection involves the liver and pancreas with corresponding crippling of the function of these important organs. Metastatic infection of the myocardium and joints may occur, especially the former.

Another hazard which a patient known to have gall stones assumes is the impaction of a stone in the common duct. The frequency of this complication appears to have been only recently recognized, which recognition has focused sharply the attention of the surgeons to the problems involved. Just how frequently this complication occurs is a question, but there appears to be accumulating evidence that it occurs more frequently than formerly thought. Lahey reports that following his more careful exploration of the common duct, he finds that 19% of his cases have common duct stones, but he says that 39% had no jaundice. Unquestionably the common duct stone is a hazard both to life and health that a patient suffering from gall-stone disease cannot afford to assume, and the dangers of its occurrence constitute a strong argument for early surgery before the complication occurs.

As evidence of the results which occur in cases not operated, a follow-up study of a series of cases of chronic cholecystitis treated medically is reported by Mason and Blackford. This study showed that two-thirds of the cases either did or should have come to surgery as the result of unrelieved symptoms or complications. One-third were entirely relieved of their symptoms by medical management. Unfortunately the authors did not specify the clinical type of cases which were relieved of their symptoms under medical management. However, as only 18.5% of the entire series gave a history of attacks of gall-bladder colic it is probable that those relieved of symptoms by medical management were patients presenting mild symptoms largely gastric in character.

In order more clearly to present this subject it is advisable to divide the cases of gall-bladder diseases into three groups, discussing the question of treatment as applied to each group:

1. The chronic uncomplicated case, with mild symptoms referable to the gall-bladder.
2. The chronic complicated case, with recurrent

symptoms indicating the presence of active infection with stones in the gall-bladder or extra-biliary ducts.

3. Acute gall-bladder cases.

It is recognized, of course, that the difficulties of diagnosis will often prevent any such arbitrary clinical classification as above suggested and especially is this true of the uncomplicated group presenting mild symptoms. It is equally true that every physician who is called upon to treat a patient presenting symptoms referable to the gall-bladder must pursue his diagnostic studies until he has informed himself as nearly as is possible of the pathology present. In so doing, he will find his cases, broadly speaking, falling under one of the above suggested clinical groups.

Group 1

In this group are to be found most of the cases of non-calculus gall-bladders, although a considerable number may be found to have stones in the gall-bladder. The frequency of the occurrence of gall-bladder disease in mild grades is a question difficult to determine. There is reliable evidence, however, that it occurs far more frequently than clinically suspected. Mentzer reports from the Mayo Clinic that in 612 routine post-mortem examinations he found 66% which showed pathological evidence of gall-bladder disease and only 8% had a primary diagnosis of gall-bladder disease. These figures show clearly that the pathological evidence upon which a diagnosis of gall-bladder disease is made is not a safe guide for the clinician.

The situation here parallels almost exactly that of the appendix wherein somewhat obscure right-lower quadrant symptoms have led to the mistaken conclusion that this organ was at fault. When removed under such circumstances, the appendix seldom fails to reveal certain pathologic changes which are sufficient to warrant the pathologist as classifying the section as chronic appendicitis. It is in this group of clinically mild cases that I believe the refinements of cholecystographic diagnosis has led in some quarters to surgical errors. This error has occurred as a result of relying upon cholecystographic interpretation as a guide to operation rather than the clinical symptoms. Graham reports 97% correct diagnosis by the cholecystogram. This high percentage is based on a check by the pathologist and not by surgical end results, wherein lies the error of relying upon the cholecystogram alone as a guide to operate. Non-calculus chronic cholecystitis and chronic appendicitis are identical in their ability to lead to diagnostic and surgical errors.

The probabilities are that in this group presenting mild symptoms usually gastric in character, liver disfunction is more responsible for the symptoms than the gall-bladder. Unless stones can be found in the course of the examination, operation is not advisable. Unquestionably, the gall-bladder has been removed or drained in large numbers of such cases, but follow-up studies show that a great many continue to have the same symptoms after operation.

The clinical picture in this group of cases is that of gastric dysfunction, gaseous disturbance of the stomach to the point of distress after eating, belching, heart-burn and a feeling of fullness. Definite attacks of pain of gall stone colic type do not occur. Deaver says that the "Difference between the symptoms of the calculus and non-calculus type of gall-bladder disease is merely one of degree and not of kind." However true this may be, the fact remains that the non-calculus gall-bladder with mild symptoms, not accompanied by current attacks of pain, gives unsatisfactory results following operation. Judd states that if the clinical history gives evidence of colicky pains the end results are good.

There are a certain number of cases in this group presenting mild symptoms in which stones are present in the gall-bladder. These are the cases of so-called "innocent" or "silent" gall stones. W. J. Mayo states that the "innocent" gall stone is a myth, and recommends removal regardless of the mildness of symptomatology. This recommendation is based upon the assumption that while the stones in the gall-bladder may not have resulted in symptoms justifying operation, their presence is a menace to the future health of the patient as a result of impaction in the cystic or common duct or their influence on subsequent gall-bladder infection.

Howard Clute of the Lahey Clinic has the following to say of "innocent" gall stones: "I would urge finally that innocent, harmless gall stones, from the surgeon's point of view certainly, and I believe that point of view should be held by all of us, do not exist and I believe if by any method one can discover gall stones, the time for medical treatment as such has ceased, and the patient's condition permitting, the moment for surgical intervention has arrived."

The preponderance of evidence seems to indicate clearly that unless stones can be discovered in this group presenting mild symptoms and unaccompanied with a history of attacks of colic, the case should not be operated. If stones are present, even though the immediate symptoms are mild, operative removal is indicated.

Group 2

In this group are to be found the cases of gall-bladder disease complicated by recurrent attacks of pain of the colicky type, produced usually by the movement of stones in the gall-bladder or extra-biliary ducts and associated with a more or less active infection. This group comprises the vast majority of cases which are clinically recognizable as presenting the typical gall-bladder syndrome of repeated attacks of gall stone colic requiring morphine to control the pain, and with an interval of quiescence in which local symptoms are absent.

There is, however, always an accompanying gas-

tric dysfunction in the interval between attacks with dyspepsia, gaseous distress and intolerance for certain foods, especially greasy, fried foods and raw apples. An apple a day will not keep the doctor away from patients suffering with advanced gall-bladder diseases. Stones will be found to complicate the great majority of these cases, although occasionally the gall-bladder syndrome will be found in non-calculus cholecystitis. The cause of such attacks of pain in non-calculus cholecystitis is hard to explain, unless it follows the passage through the ducts of small particles of sand or crystals as occasionally happens in the urinary tract.

It is in this group of cases that I believe the indications for surgery are positive. Medical management can do nothing more than alleviate the more distressing symptoms, while the underlying pathology continues to menace the patient's life and health. In a recent follow-up study of one hundred operative cases of gall-bladder disease which I made at the Robert W. Long Hospital, the average length of time the patient had suffered with gall-bladder symptoms was 15 years. As a result of this procrastination they come to operation with serious and complicated pathology involving the gall-bladder and liver with metastatic involvement of myocardium and degenerative lesions of the blood vessels.

Lahey, after emphasizing the incidence of common duct stones and the complications incident to delay, gives the following sound advice: "We must overcome the complacency with which we permit patients to go through repeated attacks of gall stone colic. We must learn that it is delay either on the part of the physician or the patient which makes the ultimate high mortality and bad results."

Group 3

Any patient suffering from gall-bladder disease, whether previously from mild symptoms or from repeated attacks characteristic of the gall-bladder syndrome, may be suddenly overtaken with violent symptoms which indicate a catastrophe some place in the biliary tract. The pathologic changes incident to this attack may be the development of an empyema of the gall-bladder, a gangrene of the walls of the gall-bladder with possible perforation, or the impaction of stones in the common duct. Any one of these conditions present the most difficult surgical problems.

Experience has shown that in the majority of these cases it is safe to wait until local and constitutional conditions have subsided before operating. Perforation and gangrene of the gall-bladder is relatively rare, although it does occur, but it is difficult to diagnose at a time when operation is of any avail. Surgeons have learned that operative trauma on an acutely inflamed gall-bladder and liver adds considerable risk to operation. On the other hand, if gangrene and perforation have occurred early operation is the only hope of recovery. The difficulty lies in being able to exclude these cases from the less serious types.

Because of the difficulties of excluding perforation and gangrene in a diagnosis, there is a disposition among some surgeons to regard acute gall-bladder infections as emergencies requiring immediate operation. If operation at this time is undertaken, something less than total cholecystectomy will be found to be advisable. If gangrene of the gall-bladder wall is present, a resection of the gall-bladder leaving only its attachment to the liver undisturbed with chemical destruction of the mucus membranes of any remaining part of the gall-bladder is a much safer procedure than total cholecystectomy. In this situation caution is the better part of wisdom. Standardized procedures which require the surgeon to fit the pathology to the operation are hazardous. Total chemical cholecystectomy, combined resection with chemical destruction of the remaining part of the gall-bladder or simple drainage may be the better choice. If jaundice is present, the risk is greatly increased and is a definite contraindication to operation in the acute cases.

In conclusion it can be said, first, that all available evidence would seem to exclude from operation all patients with definite evidence of gall-bladder disease who have mild symptoms, except those in whom the presence of stones can be demonstrated; second, that these patients who have the typical gall-bladder syndrome, or recurrent attacks of biliary colic, whether stones are found or not, should have the gall-bladder removed without delay; and third, that the acute gall-bladder constitutes an emergency in which cautious waiting under careful clinical and laboratory observation is justified. If these observations point to perforation or gangrene and there is not an increasing jaundice, operation should be done, at which time something less than total surgical cholecystectomy may be necessary.

HODGKIN'S DISEASE*

R. E. McINDOO, M. D.
KOKOMO

Hodgkin's disease is also known as pseudoleukemia, lymphosarcoma, malignant lymphosarcoma, malignant lymphoma, and by other names. The disease is characterized by an enlargement of lymph glands, and sometimes by enlargement of the spleen, a progressive secondary anemia, fever, and weakness. As will be noted, Hodgkin's disease occupies a place between the malignancies on one side and the leukemias on the other. It was first described by Hodgkin in 1832, but little attention was paid to the disease until 1856, when Wilks reported a series of cases, and the disease was named in honor of Dr. Hodgkin.

* Presented before the Howard County Medical Society, May 5, 1933.

Symptoms

In the great majority of cases, and sometimes long before symptoms are recognized by the patient, the lymphatic glands begin to enlarge. Usually the first evidence of the disease appears in the axillary glands, or those in the posterior cervical triangle. The order of frequency in regard to location of the enlargements is as follows: (1) axillary; (2) inguinal; (3) bronchial; (4) mediastinal; (5) retroperitoneal.

In cases where the glands of the thorax or abdomen are first to become involved, the primary evidence of the disease is pallor and symptoms due to pressure. These cases present great difficulty in diagnosis. If the bronchial or mediastinal glands are enlarged there is usually constant or irregular unproductive cough, which may be diagnosed bronchitis or laryngitis. If the temperature is continuous it will subside in the course of a few days or so in bronchitis; in Hodgkin's disease it may be continuous as you find it in malignancies, but it is seldom as low. In other cases and the types more often encountered the temperature may gradually increase for from four to seven days, reaching a height of 102 to 104 degrees. With this temperature the patient often complains of general pain in back and legs, and of neuritis. There is also often accompanying chills and sometimes sweats.

In abdominal types the diagnosis is made clinically. Sometimes severe pain is observed, and in these cases exploratory laparotomy in biopsy are done. The glands are usually discrete, firm, smooth, and freely movable. Aggregations of nodes may be bound together by loose connective tissue to form large masses. The glands on one side of the neck may be enlarged for some time before those on the opposite side become involved. In many cases the extension advances to the other side of the body.

When the submaxillary glands are the first to show involvement, extension to the other side is more rapid. The enlarged glands may encircle the neck and interfere with the movement of the head. The swelling may involve the mastoid and occipital regions. Sometimes after a group has enlarged, diminution in size occurs and the disease apparently becomes quiescent. It may burst forth suddenly and terminate rapidly in death.

Pain does not accompany the enlargement of the glands and when present is due to secondary inflammatory changes or to pressure upon the nerves. Where axillary gland involvement is seen, edema of the arm and hand are found.

In submaxillary involvement, mastication may be interfered with by the large masses of the glands. Pressure upon the esophagus may cause dysphagia and in rare instances complete occlusion.

Bronchial gland involvement causes difficulty in breathing and an unproductive cough.

Anemia of the brain may be caused by pressure on the carotid arteries, in which event tinnitus aurium, dimness of vision, and vertigo upon slight exertion may be observed. If the growth exerts sufficient pressure to further diminish the amount of blood distributed to the brain, irregular breathing occurs with convulsions, coma, and even death following. Deafness is a common symptom due to pressure upon the eustachian tube. Very pronounced cardiac irregularity may be the result of pressure upon the vagus nerve. There may also be paralysis of the larynx. Pressure on the trachea or bronchi results in cough and dyspnea. Some cases show edema and cyanosis of the head, face and arms due to compression of the superior vena cava. A unilateral or bilateral pleural effusion may be present, caused by direct irritation of the pleura from enlarged glands or from compression of the bronchial veins; on percussion there may be no resonance and an exploratory puncture will reveal very small amounts of fluid in the majority of cases.

Severe pain, edema, and cyanosis of the arms may result from pressure exerted by the axillary nodes. A similar disturbance may result in the legs as a result of pressure exerted by the inguinal, pelvic, or retroperitoneal glands. Sciatica is sometimes severe in character. One of my patients required narcotics for almost three months.

If the common bile duct is obstructed, jaundice is often seen. Secondary metastasis occurs in the lungs, causing cough and expectoration. Nausea, vomiting, and diarrhea may be caused by involvement of the lymphoid tissue of the gastrointestinal tract. Ulceration of the stomach or intestines may cause hemorrhage from these organs. Constipation may be caused by pressure upon the sigmoid or rectum; complete obstruction is very rare.

Secondary growths of lymphatic tissue may occur in the liver and kidneys, but rarely causes symptoms other than slight jaundice. The spleen often is somewhat enlarged though never reaching the size that occurs in leukemias. The enlargement is not associated with pain. Pruritus may be an extremely annoying symptom. Bronzing of the skin, suggesting Addison's disease, occurs in some cases. There may also be glandular enlargement in the skin.

Fever is present in the majority of cases. It may be irregular in type and may be absent for a considerable period. It may be continuous or may be relapsing in type, and may reach 103 or 104. In some of my cases the temperature would ascend about one degree each day; morning temperature is one or two degrees lower than evening, until the temperature reaches 102 to 104 degrees and gradually drops in the same fashion. X-ray at this time often checks this cycle. After a period of four to ten days the temperature drops and becomes subnormal for a day or two, and this same cycle may be repeated for months.

Blood examination shows a progressive secondary anemia; the erythrocytes may be less than 2,000,000 and a hemoglobin may reach 40%. The

leukocytes may be normal or may reach 25,000 per c.m. The polymorphonuclear leukocytes usually number about 70%; a high count is the result of secondary infection. The lymphocytes may be increased, but more commonly the eosinophiles are increased, and in one of my patients reached as much as 16%; several counts averaged 8 to 10%.

Diagnosis

This disease is often difficult to diagnose without histological study of an excised gland.

Diseases that must be differentiated are:

(1) Tubercular glands. Age, usually younger. Tuberculin test, complement fixation, sputum and x-ray examinations are necessary if pulmonary complications are present. Tubercular glands usually break down, the skin becomes adherent, and feels softer, differential count, temperature is not characteristic, finally histological examination.

(2) Lymphosarcoma. Clinically these diseases are similar; structure of glands is different. In Hodgkin's disease the glands contain an increased amount of connective tissue and three types of cells, mainly lymphoid cells, giant cells with one nucleolated nuclei; and in most cases eosinophile cells. In lymphosarcoma the mass is composed of delicate reticulum in the meshes of which lie cells larger than lymphoid cells.

(3) Simple infectious adenitis. This type of fever is septic inflammation of the skin, attempt toward pus formation, history of time, leukocytosis, lack of eosinophilia.

(4) Secondary metastasis. History of primary lesion near by such as breast, spine, bony structure, etc.

One of the best distinguishing characteristics of an enlarged gland of Hodgkin's disease is the disappearance, partially or wholly, of the gland under x-ray or radium therapy. Malignancy of practically all organs may be eliminated by x-ray examination or functional and clinical tests.

Etiology

The cause of Hodgkin's disease is still in doubt. Formerly the disease was thought to be a malignant growth. It is now generally believed that it is infectious. This belief is supported clinically and histologically. Sternberg in 1898 stated that the disease was a special form of glandular tuberculosis. Fraenkel and Much, 1910, found an organism resembling the tubercle bacillus in twelve out of thirteen cases of Hodgkin's disease, all of whom were clinically and anatomically free from tuberculosis.

The organism appeared as granular rods which resisted anti-formin stained by Gram's method, but were not acid fast. Negri and Miermet confirmed the findings of Fraenkel and Much, but stated that the organisms were not related as tubercle bacillus, but a diphtheroid organism which belonged to the species of Corynebacterium. These men isolated the bacteria and were able to produce a disease in monkeys by inoculation similar to Hodgkin's disease.

The disease occurs most commonly in males and usually before the fortieth year. In Longscope's series of cases, the youngest patient was seven and the oldest was thirty-five years of age.

In a series of six cases I have treated or seen in consultation, two were females aged sixty and sixty-seven, four were males with ages varying from twenty-seven to fifty. The manifestation of glandular enlargement was first evident in one male, aged fifty, submaxillary; one male, aged forty-eight, axillary; one male, aged thirty, mediastinal; one male, aged twenty-seven, supraclavicular. Both female patients had mediastinal involvement as first symptom. Of these two, one patient had a mistaken diagnosis of gastric cancer. X-ray evidence at that time showed the mediastinal glands to be enlarged. The other patient had a cough for some months with progressive anemia before consulting a physician.

The duration of Hodgkin's disease varies from a few months to several years. The exact study of duration is impossible because of the difficulty in determining the time of onset. The disease may exist for years without any enlargement of the external glands; in other cases there may be slight enlargement of single groups of external glands. Then suddenly, general enlargement, with pronounced constitutional symptoms may occur, followed by death within a few months.

In most cases the cause of death is asthenia. The patient becomes more anemic; edema and finally anasarca occur, dyspnea increases, weakness becomes pronounced, and finally death ensues.

Death may be sudden; it may be caused by starvation due to pressure against esophagus, or from suffocation due to pressure on the trachea; under x-ray therapy this kind of death is seldom seen.

In my series of cases three that had x-ray therapy died from gradual exhaustion and toxemia. Two women had metastasis in one lung. X-ray therapy is able to control glandular growth sufficiently to prevent death by starvation or suffocation. In one patient, in whom an excised gland proved histologically to be lymphosarcoma, x-ray therapy was instituted and after a lapse of six years there has been no recurrence.

Treatment

Up to present time no treatment has been effective in saving the life of the patient. Of drugs, arsenic is favored. Liver extract and tonics are indicated to combat the anemia.

Under x-ray therapy the glands gradually diminish in size, and the general state of health improves. Often marked improvement follows a single treatment; the glands diminish; the fever disappears; and a state of well being apparently exists. Later other glands may enlarge with all the constitutional symptoms. We hope that soon a vaccine or serum will be found to effect a cure of this disease.

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OCTOBER, 1933

EDITORIALS

THE FRENCH LICK SESSION

Scientific papers and stag parties, golf and good food, economic round tables and eminent essayists, medical politics and Pluto, combined to make the eighty-fourth annual session at French Lick, September 25 to 27, a grand and glorious three days, long to be remembered in the history of the Indiana State Medical Association. From the time the advance guard rolled in on Sunday afternoon for a few practice rounds of golf until the session ended in an annual banquet in honor of Dr. Walter L. Bierring of Des Moines, Iowa, president-elect of the American Medical Association, and Dr. Morris Fishbein, editor of The Journal of the American Medical Association, there was not a dull minute for every one of the 637 physicians, their wives and guests who attended the meeting. There have been larger state meetings, but there never was a more enthusiastic nor friendly one. The convention setting was perfect at the French Lick Springs Hotel, and before the three days had elapsed every one had had an opportunity to know every one else and had taken it, and all left with a feeling of confidence that, despite the uncertainties that may lie ahead, the Indiana State Medical Association is in first class order.

The battle for the presidency was typical of the keenness that dominated both sessions of the House of Delegates. In one of the hottest battles in the records Dr. Walter Leach of New Albany, who had served his district as a councilor for more than twenty years, was elected on the third ballot over Dr. R. L. Sensenich of South Bend, Dr. W. F. Carver of Albion, and Dr. Walter McFadden of Shelbyville. Dr. A. F. Weyerbacher of Indianapolis was re-elected treasurer, while Dr. Don Cameron of Fort Wayne and Dr. F. S. Crockett of Lafayette were re-elected delegates to the American Medical Association to serve for two years. With Dr. Homer Hamer of Indianapolis and Dr. R. L. Sensenich they will represent the Indiana State Medical Association during the national meeting at Cleveland next June. Dr. W. F. Carver of Albion and Dr. G. D. Scott of Sullivan were re-elected as alternates. The election of councilors for the following three districts was approved by the House of Delegates: Second District, Dr. H. C. Wadsworth of Washington; Fifth District, Dr. O. O. Alexander of Terre Haute; Eleventh District, Dr. George D. Miller of Logansport. The representatives of the Eighth District reported that they would have a meeting soon for the election of their councilor.

Dr. E. M. Shanklin of Hammond was re-elected editor of The Journal for 1934, while Dr. L. P. Harshman of Fort Wayne was elected to serve the term of five years as a member of the editorial board, these selections having been made by the Council.

Section officers for 1934 were elected as follows: Surgical Section—Dr. H. C. Ragsdale, Bedford, chairman; Dr. Don Cameron, Fort Wayne, vice-chairman; Dr. William C. Reed, Bloomington, secretary. Medical Section—Dr. C. J. Clark, Indianapolis, chairman; Dr. B. S. Cornell, Fort Wayne, vice-chairman; Dr. A. S. Giordano, South Bend, secretary. Section on Ophthalmology and Otolaryngology—Dr. J. R. Gillum, Terre Haute, chairman; Dr. C. Norman Howard, Warsaw, vice-chairman; Dr. R. R. Calvert, Lafayette, secretary.

The following officers were selected for the Woman's Auxiliary: Mrs. I. N. Trent, Muncie, president; Mrs. E. D. Clark, Indianapolis, president-elect (1935); Mrs. R. L. Compton, Osgood, vice-president; Mrs. Fred Wishard, Anderson, recording secretary; Mrs. Frank Gastineau, Indianapolis, corresponding secretary, and Mrs. U. G. Poland, Muncie, treasurer.

Out-of-state speakers who helped to make the scientific programs unusually interesting were Dr. H. C. Ballenger of Chicago, Dr. L. J. Hirschman of Detroit, Dr. Arthur H. Curtis of Chicago, and Dr. Ernest Sachs of St. Louis.

The scientific meetings were well housed, the instructional courses, an innovation last year, on the first morning of the meeting once more received the hearty approval of the audience.

The scientific exhibit, under the direction of Dr. Ernest Rupel, was an attractive feature, Dr. Thurman B. Rice, Dr. R. N. Harger, Dr. Verne K. Harvey, Dr. C. P. Clark, Dr. J. E. Dalton, and Mr. Thomas G. Hull of the American Medical Association having arranged interesting displays. The American Medical Association had a particularly attractive exhibit and the Association appreciates the splendid cooperation it has received from Mr. Hull, who arranged and conducted the displays.

Despite cloudy weather and frequent showers, more than one hundred golfers turned out to play

the sporty French Lick Country Club course Monday morning and to compete for the most elaborate list of prizes ever assembled for an Indiana state meeting. Dr. Robert Acre of Evansville won the Armstrong challenge trophy and the 1933 championship with a well-played low gross score of 78, while Dr. Cleon Nafe of Indianapolis was runner-up with an 82.

The business meetings of the Association got under way Sunday evening with the regular monthly executive committee meeting. The Council held its first meeting Monday noon with Dr. O. O. Alexander, chairman, presiding over the group, which was one hundred per cent in attendance. Proceedings in the House of Delegates went ahead under the able direction of Dr. J. H. Weinstein, president, without a hitch. The reference committees, to which were assigned a tremendous amount of material, did their work in splendid fashion with the result that many valuable policies were laid down and much valuable material for the guidance of both the state and the county societies was made available for the coming year.

The complete report of the executive committee, the Council, and the House of Delegates meetings will be printed in the November issue of THE JOURNAL, but several high points of the meeting are mentioned here as follows: The House defeated the amendment to the Constitution and By-Laws which would have provided for the creation of a speaker and vice-speaker. The House adopted a resolution which changes the Constitution and By-Laws, giving the president-elect a place upon the executive committee and making this officer an ex-officio member of the Council and the House of Delegates in place of the editor of THE JOURNAL. Resolutions in regard to giving gratuitous information to insurance companies and providing for a later date for the state meeting were introduced and passed. The resolution introduced last year in regard to the medical defense fund became so inwrapped in a maze of technicalities that it was most difficult for many of the House members to understand what it was all about. However, after a spirited discussion, the House voted that the sections of the By-Laws governing medical defense should not be changed at this time.

Every one agreed that the Third District and the Orange County medical societies had put on a program of entertainment that had never been excelled at any annual session. Outstanding attractions were the stag dinner and the annual banquet, which were novel in every respect, the many fraternity and get-togethers, the mystery field day, the tea and the visit to the beautiful Taggart home and gardens, and the trip to Spring Mill Park. The appreciation of the Association should go to Dr. C. E. Boyd, president of the Orange County and Third District medical societies; to Dr. George Dillinger, general arrangements chairman and secretary of the Third District and Orange County medical societies; to Dr. H. D. Ragsdale, councilor of the Third District; to Mrs. George Dillinger, who acted as general chairman of women's entertainment; to Dr. A. P. Hauss of New Albany, who was in charge of the golf tournament and was chiefly responsible for the array of prizes; to Dr. R. B. Smallwood of Bedford, who arranged for the fraternity and ex-service men's dinner and get-togethers; and to Mr. H. J. Fawcett and Mr. Thomas Taggart for the many extra courtesies extended by the French Lick Springs Hotel.

From a general interest standpoint perhaps the most outstanding event of the entire meeting was the economic round table luncheon discussion conducted by Dr. E. E. Padgett, president-elect. Governor Paul V. McNutt and William Book, state relief director, were the principal speakers outside of various committee chairmen of the Association. Governor McNutt expressed his utmost faith in the medical profession of Indiana and his desire to cooperate with the profession in its battle to maintain proper standards of medical education. The Governor, particularly, and at a later meeting Dr. Verne K. Harvey, director of the State Department of Public Health, spoke of the new set-up of the State Health Department and the Indiana plan and besought the cooperation of each and every physician to make this a success. Mr. Book spoke in detail of the plan which had been worked out to make federal emergency relief act funds available to Indiana physicians for medical services rendered the indigent sick. Mr. Book answered many questions and clarified the situation in the minds of many physicians present. The Governor's speech and a detailed report of the discussion and talk by Mr. Book will appear in the November number of THE JOURNAL.

Other meetings during the convention were those of the editorial board, the meeting of the laboratory directors, who formed an Indiana State Laboratory Association to which all physicians doing laboratory work are invited to become active members and technicians to become associate members, and a meeting of the child welfare committee of Indiana. Officers for the laboratory association were elected as follows: Dr. B. W. Rhamy of Fort Wayne, president; Dr. Harry Langdon of Indianapolis, vice-president, and Dr. A. S. Giordano of South Bend, secretary-treasurer.

SILICOSIS, AN INDUSTRIAL HAZARD

Recent medical literature has carried a large amount of comment on the subject of silicosis in connection with some of the industries, particularly those having to do with sand, gravel, and certain of the various ores. That there is nothing new in the discovery that this condition is an industrial hazard is evidenced by the fact that the ancients were fully aware of the fact that the inhalation of mineral dust often produced most unhappy results. Those thus exposed were commonly found to be infected with pulmonary tuber-

culosis at some later period. It is only in recent years, however, that any great interest has been aroused concerning the subject, and this interest probably has been brought about by the large number of suits instituted before various Industrial Boards, based on the allegation that the physical condition of the claimant was caused by dust inhalation.

In 1916 the U. S. Public Health Service became interested in the subject to the extent that a rather complete survey of the situation as it existed in Joplin, Missouri, was made. An interesting and complete report of this survey, together with a rather exhaustive study of the problem, appears in the August number of the *Journal of the Missouri State Medical Association* from the pen of Dr. Louis C. Boisliniere. He reviews the historical phases of the subject and also has much to say regarding the pathology of the disease and its sequelae.

That silicosis is a potential disease in many of our industrial sectors is evidenced by the fact that it is found among granite workers, sand blasters, miners (not including coal miners), pottery makers, gravel grinders, and glass workers, and this is mentioning but a few of those likely to be thus affected.

A short time ago a St. Louis newspaper carried the somewhat startling story that the claims against a lead company in that state amounted to the sum of five million dollars, and that approximately a half million had been expended in the settlement of a part of these claims! In the State of Illinois there were filed twenty-three suits within a period of two days. Thus it will be seen that there is some merit in the observation that the subject is an important one.

It is stated that free silica (silicon dioxide, SiO_2) is the only direct phthisis-producing dust, and this must be present in the air breathed to a degree of at least fifteen per cent. One should also bear in mind that these silica-bearing dust particles must be extremely minute in order to reach the alveoli. It has been observed that mouth breathers more readily acquire silicosis than those who breathe normally. "Silicosis is a progressive disease acquired over a long period of exposure and ranging from little or no pulmonary disturbance and no impairment of industrial capacity to complete lung dysfunction, permanent invalidity, and even death." It is believed that silica undergoes a slow solution in the lung and thus becomes a direct cell and tissue poison; thus may we have stimulation of old latent tuberculosis lesions lighted anew.

It behooves the doctor engaged in industrial medicine and surgery in connection with factories concerned with silica-bearing materials to brush up on this interesting subject. One of our friends recently brought the matter to our attention with the statement that one of his industries, a foundry where the employes worked with silicates to a large degree, was contemplating a wholesale x-ray examination of the chests of their employes. While the literature on the subject is not voluminous there is much to be read, and its perusal will prove of more than ordinary interest to those concerned.

THE BARBERS' BOARD

The 1933 session of the Indiana legislature enacted a law providing for the licensure of barbers, including "hair cutters" attached to beauty parlors. For some years past the Master Barbers' Association has made strenuous efforts to obtain such legislation, the chief argument in favor thereof being that registration would serve to bar from our state many barbers who were unable to obtain licensure in the adjoining states. However, the Association, as stated by some of its most active members, was not quite prepared for some of the surprises attending the enforcement provisions of the law.

Soon after the board had been appointed one of the appointees resigned, his reason therefor not being made public, but we are unofficially advised that he objected to the set-up of the board.

Among the various provisions in the law was that calling for a complete physical examination of all applicants, including a blood Wassermann. This, of course, is eminently fitting and proper. The law provides that these examinations shall be made by regularly licensed physicians who are to be appointed by the board, and it seems that the appointments were made by the patronage system.

Judging from the amount of correspondence sent in to The Journal, it is apparent that this part of the procedure is not to the liking of a considerable number of our members. We have had some very definite complaints in the matter via the mails, together with a lot of verbal quibbling over the appointments. We believe we are agreed in the premise that barbers should be examined ere they are licensed, particularly in the matter of the Wassermann tests; but it seems that the question of who shall do the examining is quite another matter, according to the protests we have had. One writer from the northern part of Indiana asks the question, "Will you please explain how the State of Indiana can force the patients of a recognized and legally authorized physician to go to another physician for an examination and certificate of health which the former physician is qualified and legally authorized to make? A political appointment—yes; but wherein lies the justice?" In the present instance the appointing committee has arguments of considerable merit to support its position. For example, the fact is cited that life insurance companies have their special examiners who examine those who are patients of other physicians. Again, just now when so many of the larger industrial corporations are making examinations of all employes, these examinations

are made by the company physicians without regard to the so-called family physician of the employe. So, they maintain, their position is quite tenable. Our Association is and always will be opposed to the political appointments of physicians in civilian population.

From another writer comes the following complaint: ". . . Furthermore, the appointments in this particular locality smell strongly of political patronage . . . all four local appointees are definitely known to have political connections with the party in power. . . . We believe immediate and drastic action should be taken to abolish and check this discriminatory and unjust political intervention in our field, for it is not only unfair but is contrary to one of the cardinal principles of our society-free choice of physician."

Time was when the various state boards made their own appointments, though probably they "conferred" with the "powers" ere the appointing was done; at present, it would seem, appointments are made by the patronage committee and made with a view to making the best political bargain possible. As a matter of cold fact, we shall have to recognize the old political adage, "To the victor belongs the spoils!"

THE DOCTOR AS A BUSINESS MAN

What about the doctor as a business man? Well, for the most part, he just isn't. That observation is being borne out, just now, in the matter of the Home Loan Corporation. Some time ago we were invited to assume the chairmanship of the board in our county and almost immediately we were besieged by those whose investments were in more or less distress—usually of the "more" variety. Not a few of those who consulted us were physicians.

The tales that some of these men unfolded would make even the former president of a closed bank do a tall job of weeping; the utter ignoring of all the laws of finance, the rushing headlong into real estate "deals," all without any frank consideration of the safety element, the cocksureness with which they assume that even now all will come out to their liking—all these things bring to us the question, "Why do so many physicians make a flat failure of their business affairs?"

It is true that they all use the old alibi, "Why, I had implicit confidence in that man," usually referring to their bankers. And that is generally true; for years we have been urged to "consult your banker before investing." After all, this thing of confidence is the great big element in all business; if there is no confidence in the other fellow, and for a time it did seem there was no such thing, there would be no business.

For the very life of us we cannot see why educated men will fall for the glossed and highly enameled tales of stock salesmen who preach get-rich-quick gospels, the process of getting rich being based on oil stock, gold mines, and all that sort of thing. We recall, some years ago, a phone call; the gentleman on the other end of the wire stated that he was calling from Chicago; that he had a hot tip on German marks and that said marks were about to take a high and mighty leap; that for a few hundred dollars the marks could be margined and in a few days we would have so much money we would want to retire. When asked why we had been selected as one of a select few to profit by such a transaction we were advised that some friend of ours, a member of the stock broking firm, had placed us on the favored list. We did not make the purchase, much to the wonderment of the caller, for he "could not understand why we did not want to take advantage of the magnanimous offer to become a big shot, financially, in our home town." At noon, on the same day, we met several friends, all of whom had been similarly solicited and none of whom knew any one connected with the brokerage outfit. (Not long after this we learned that the brokers in question had decamped, taking with them several thousands of dollars of the other fellows' money.) Yet, in spite of the glaring impossibilities of the story the caller gave to his intended victims, he found suckers in our community, some of them physicians and dentists.

For a rather long period we of this community ceased consulting our bankers; a lot of folks were trying to insult them, instead, for the reason that *all* our banks had closed and for the further reason that they had so effectually cleaned us that we had no money to invest or to bother about.

With the expected pick-up in business and the restoration of trade in general, we may expect again to accumulate a few dollars and, most of us having learned many lessons in finance, it is to be expected that for a time at least there will be fewer "investments" of the wildcat variety than before. But folks soon forget; they want to take another flyer; and no doubt the sucker list—invariably headed by the medical profession—will again be a salable commodity.

All of this brings to mind the fact that in addition to teaching the art of medicine to our candidates for the profession, we must give them more than a bit of a course in economics. Our own Indiana University, Department of Medicine, has made a good start in this direction; the course presented during the last semester offered a lot of good, wholesome advice on the general subject of economics as applied to the medical profession, and it would seem that the subject is soon to become a major one in the better schools. This is as it should be; it is more than unfair to graduate a class, crammed to the utmost limit with medical erudition, but with not one iota of an idea as to the matter of medical economics; it borders on the criminal; these young men and young women should be taught the elements of medical economics at least, that they may know that there is more to the practice of medicine than practice, for the matter of bread and butter and the matter of finance is an essential in their professional lives.

EDITORIAL NOTES

Dear Doctor:

The Journal and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospitals.

We invite and urge you to use this Service.

It is absolutely *free* to you.

The Cooperative Bureau is equipped with catalogues and price lists of manufacturers, and can supply you information by return mail.

Perhaps you want a certain kind of instrument which is not advertised in The Journal, and do not know where to secure it; this Service Bureau will give you the information.

Whenever possible, the goods will be advertised in our pages; but if they are not, we urge you to ask The Journal about them, or write direct to the Cooperative Medical Advertising Bureau, 535 N. Dearborn St., Chicago, Illinois.

We want The Journal to serve *you*.

Do not overlook the very pertinent fact that The Journal is made possible by our advertisers. This being true, they have the right to expect the support of our membership. Are YOU doing your part toward such support?

The Indianapolis *Star* for September twelfth carried an item stating that the state has filed suit against the Physicians' Protective Casualty Company for receivership. We understand that the company has been placed in the hands of the receiver. It is called to the attention of policyholders that policies of this company contain an assessment clause.

Anent an editorial in a recent number of The Journal, an association member writes: "I have placed the editorial in a scrap book, along with other similar articles, which I keep on my waiting room table." Quite a happy thought, that; waiting patients, always eager for something to look over while awaiting the doctor, will fairly "eat up" little scraps of medical interest, such as the editorial in question. Would that all our members might be so ambitious in preparing such reading material for lay consumption!

An inquiry was received from a member, a short time ago, as to why The Journal carried no abstract of an article which had been published elsewhere. The answer was, of course, that we had failed to see the article; we do not have access to the journal in question and our attention had not been called to it. While we do not see *all* the journals published in America, we do manage to go over some sixty odd numbers each month — quite some little task, that. We will be glad to abstract any articles published by our members if they will be good enough to direct our attention to same.

The current bulletin of the Fort Wayne Medical Society carries a naive statement from the secretary; speaking of programs for the coming year he says, "One young man has already informed the secretary that he does not care for any more papers on the prostate this year." The secretary then adds the comment, "It must be great to be sure of the future!" Our own observation is that said young man is some optimist!

A first-minute notice to those of our readers who have not yet paid their state gross income tax, same being due as of October 15th and to be paid for gross income during July, August and September. Whatever may be our opinion regarding this tax, the fact remains that the law is still in effect and it is up to us to pay the fiddler, willy-nilly. Personally we are getting somewhat tax-shy; seems as though the word tax meets us on every turn these days.

Maxcy (*Virginia Medical Monthly* for July) presents an exhaustive study of undulant fever and its relation to Brucella infection in cattle and swine of Virginia. In this study he had the assistance of L. E. Starr, D. V. M. Many positive reactors were found in the cattle and swine herds of Virginia. In tracing the source of infection in several cited cases, the use of raw milk was usually charged with being the source of the disease. Altogether it is a most interesting article and will receive much commendation from those interested in preventive medicine.

The International Assembly of the Interstate Postgraduate Medical Association of North America will convene in Cleveland on October 16th. A review of the announced program reveals an unusually interesting group of papers and clinics, and Indiana will no doubt furnish a large per cent of the attendance. It is by far the most intensive course of study in America and has come to be regarded as a veritable fountain of last-word information in the various branches of medicine. An appealing feature of these meetings is the ultra business-like method of carrying out the program; everything operates on an exact schedule, and when a speaker's time is up, that just ends it without further ado.

To those of our profession who still see state medicine in the offing (and most of us see enough to be ever on the alert), the Barbers' Bill is but another entering wedge for state medicine in Indiana and into what we were wont to call our rights and privileges as licensed practitioners of the healing art. Just what can be done about it we do not know; the facts are that ere we can decide what to do about it, all of the examinations will

have been made. This whole mess (and isn't it a mess?) is but another irrefutable argument that the medical profession must become more active in politics. That a group of over four thousand trained professional men should have to sit supinely and see their rightful prerogatives snatched from them by a group of so-called politicians is a sorry indictment—an indictment for which we need not stand trial if we will but exercise the remedy that is ours.

WE have encountered many oddities these taxpaying times, but ran across a new one just the other day. A few weeks ago an internal revenue man barged into the office with the information that there was an error in our return for 1932, said error resulting in an indebtedness on our part in a sum of less than five dollars. He remarked that the return had been made by the local deputy, which led us to believe that our sole duty was to kick in with the amount named. When he asked us to sign a certificate of indebtedness, we had no hesitancy in so doing. Now we get the rather startling information that, because of the delayed payment, there is a matter of forty-one cents *interest* due and owing to the government. Of course we have paid the claim and accrued interest, but cannot help wondering just why we have to pay *any* interest when the error was one of computation on the part of the deputy. Well, we live and learn!

YOU have no doubt received from the directory department of the A. M. A. an information card which you are asked to fill out. Since these cards are prepaid and it requires but a moment to fill in the necessary information, it would seem there should be no necessity for calling the attention of our members to the matter. However, our previous experience has been that medical men are prone to neglect all phases of correspondence, and this note is to remind you that you should dig up the card from your unopened and unread mail, insert the desired information, and send it along. On the other hand, if you do not receive such a card by October first you should write to the A. M. A. headquarters, 535 North Dearborn Street, Chicago, or get in touch with Tom Hendricks at our own headquarters. You will find it very much worth while to be properly listed in the A. M. A. directory, probably the most informative medical publication in North America.

FROM time to time we have advanced various reasons why one should not neglect payment of his medical dues. Now comes an announcement that furnishes an additional reason—the forthcoming issue of the Directory of the American Medical Association, this to be the thirteenth edition, issued early next year. In passing we may make the comment that another directory will not be issued for at least two years. Those familiar with the directory will recall that all members of our county and state medical societies, as well as of the A. M. A., are properly designated in the directory, their names appearing in bold type. Nonmembers are listed in smaller type, the classification being such that he who is seeking information about physicians will at once pass over the nonelect. All of which means that former members who have not paid their 1933 dues will find themselves somewhat obscurely catalogued in the 1934 A. M. A. Directory. A word to the wise, you know!

A LITTLE while ago we had something to say about having THE JOURNAL mailed to your home address, this with a view to having the "Missus" look it over, if she cared to do so. We had no particular idea in mind in making the suggestion, other than the fact that we have frequently talked with wives of doctors who expressed more or less interest in our official publication. Now comes the suggestion from the Cooperative Medical Advertising Bureau, an A. M. A. subsidiary, that such a plan not only creates a more active interest in medical affairs on the part of our women folks, but that there are almost unlimited possibilities in the way of increasing our advertising. *Women do read the advertisements*, there can be no question about that; and if they are afforded the opportunity they will read certain of the advertisements appearing in THE JOURNAL. Therefore, as pointed out by Mr. Mattson, head of the Bureau, we are overlooking a good bet if the opportunity is not given. If we can but persuade our members to have their JOURNAL mailed to their homes, then add a little propaganda of the proper sort among the members of the Auxiliary, we will have a potent argument to present to manufacturers of various articles commonly used about the home, not overlooking the various so-called health foods. At any rate it is something worth thinking about.

WE were considerably "put out" when we learned that Richard Lieber had been deposed as head of the Department of Conservation some few weeks ago. We had hoped that the "spoils system" might not be so far-reaching. Colonel Lieber has done a monumental piece of work in the building of our state park system; he thoroughly believed that Indiana should preserve her various spots of natural beauty, and a right good job he has made of carrying out that belief. That he should be removed and his place filled by one who is at least not so well known in this particular field is very much regretted. We also regret the resignation (?) of Dr. O. R. Lynch, for many years superintendent of the Logansport State Hospital. Dr. Lynch is

one of the outstanding men in this particular field, and any one who has followed his annual reports from year to year must be thoroughly convinced of the truth of that statement. He is an Indiana man, a graduate of the Indiana University School of Medicine, and has spent practically all of his professional life in doing psychiatric work. We regret to the utmost the severance of his connection with the Logansport State Hospital, feeling that his "resignation" was not due to other than political exigencies. Politics should have no place in the various state hospitals.

John T. McCutcheon, the Hoosier cartoonist of the Chicago *Tribune* (he may aptly be described as the greatest of cartoonists), breaks forth with one of the cleverest of his many pictures in a recent issue of that daily. The picture is in two sections, which bear the titles "Waiting for the Doctor" and "Making the Doctor Wait." The first picture portrays a scene, commonly met, of distracted parents 'phoning their doctor; the baby is in convulsions, and "hurry" is the word. The time is about 2:00 a. m. The pathos portrayed on the faces of the parents is done in the best McCutcheonesque style. The second picture shows the same family, but in a different setting. The wife is engaged in the delightful pastime of planning the summer vacation; she has the vacation folder before her. The child who caused the doctor to make the hurry-up night call is watching his father, who is seated at the family desk, going through the mail, smoking his evening pipe and seemingly is at peace with the world. The date is September second. Appearances indicate that all the monthly bills have been paid, as the waste basket is well filled and there are no papers on the desk, save one, the envelope that contained the doctor's bill, which the head of the house is contemplating. His comment is, "Th' doctor's bill. Oh well, he can WAIT." The appealing thing to all medical men who have seen the cartoon is the stark fact that it is all true; the doctor can and does wait! Thank God for John T. McCutcheon!

Quite a sizable group of former members have overlooked the little formality of paying their Association dues for 1933. We would again remind these folks that this little oversight may be extremely embarrassing one of these days, particularly in the case of those who have depended on the Association for their medical defense. As we have very frequently observed, malpractice suits are on the increase, and no one can tell when he may be the victim. The Association has been very successful in looking after the interests of its members in this regard and it behooves all to do their part, which in this instance means the payment of the annual dues. Varied are the excuses proffered when a delinquent is solicited for his annual payment, chief of which is the asservation that they simply cannot afford it. This may be all very true in the majority of instances; that is, a man may feel that he simply cannot dig up the ready cash. On the other hand, we can cite innumerable instances where said delinquent spends many times the amount of his annual dues for inconsequential things. One man of our acquaintance is constantly "putting up a poor mouth," yet he finds available cash to spend some fifty dollars per year as a member of a luncheon club, is rarely missing at any of the major social affairs of his community, and manages to finance a party or two which his better half gives at a rather pretentious hotel in an adjoining city. Better see your secretary right now and get in line; after getting in line make it your first business in 1934 *to stay in the line.*

In this issue is an article on "Medical Care of the Indigent in Indiana." On going over this survey one is impressed by the great amount of thought and work applied to this problem by physicians in widely separated sections of the state, in a quiet way and with little publicity. It is, of course, traditional and altogether admirable, but the problem is of such magnitude that it must be solved with the state as a whole in mind as the major premise, and with provision for local variations a secondary consideration. It must be conceded that, as a state, medical care of the indigent in Indiana has been a chaotic affair, for the most part with little improvement over rather ancient methods. If a plan applicable to the entire state can be worked out in harmony with the powers-that-be, it will indeed be a myopic physician who will not do his bit to make the thing work. While any such plan undoubtedly will embody a fee schedule with fees much less than the usual amount, it will be well to bear in mind two things: (1) while a few may have received adequate compensation for this work in the past most doctors have received nothing; and (2) this is an emergency for the state, the poor, and the medical men alike. Physicians are careful in the case of private patients, but it is no less important when dealing with civil authorities to remember that we are doctors, not artisans—professional men, not merchants; and we should conduct ourselves in such a manner that any consideration of our affairs follows the line of honor and dignity as a matter of course. In trying times we are apt to put self before profession, always with disastrous results. A glance at the map accompanying the article referred to makes one wonder whether the dignity of the profession is being properly upheld in Indiana; and if any one scoffs at dignity in these days of unrestraint, let him reflect but a moment and he will see that in the *dignity* of its present achievements lies the future of medicine as a profession.

THE PRESIDENT'S PAGE

The Association has never been more active than during this past year. Its many and varied interests in behalf of the profession, for the betterment of organized medicine, and the reorganization of the public health service was demonstrated by the numerous problems discussed at the last annual session.

It is never possible to have everyone satisfied in the solution of any question, but I believe the large majority is pleased with the way the different committees handled their work, and the reports made by them. The report of the executive committee was the most complete ever presented and gives a splendid abstract of work done. Those members having sufficient interest to take time to read it carefully will gain some idea of what is being done in the society. If the reading of this report be supplemented by reading the report of the Publicity, the Civic and Industrial Relations, the Legislative, the Education and Hospitals, and the Public Relations Committees, one may become quite thoroughly acquainted with "what's what" in the Indiana State Medical Association.

Review of Association Work in 1933

Reviewing, in my mind, some of the work done this year by the Association, there are four especially high points that stand out, showing the willingness to work and the desire to help.

1. The secretaries' conference in January. It was well attended and the various questions confronting the secretaries thoroughly discussed. They returned home well informed and prepared to give to their local societies much information, laying the foundation for a singleness of purpose in achievement.

2. In May the chairmen of the committees met with the Council and Executive Committee. The benefit of this meeting is evidenced by the reports already printed last month in THE JOURNAL.

3. August saw a climax, apparently, of the indigent sick question and some thirty-five surgeons from all parts of the state were asked to come to Indianapolis to discuss the question of surgical care of the indigent. Thirty doctors responded to the hurried call and remained in continuous session from eleven to five o'clock. While at this writing it appears that this may have been love's labor lost in accomplishing an understanding with the Governor's committee, yet the bright spot which stands out is the prompt and hearty response of the busy doctor to the call of duty for benefit to his brother practitioner.

4. About thirty days' time was all the notice given to prepare for an exhibit at the State Fair. This was pioneer work; there was no precedent to follow. So successful was this maiden effort that unquestionably it will be repeated and enlarged next year.

It seems strange—the psychology of doctors. After the initial investment for diploma and license, so many doctors feel they have finished and need not invest any more money, either for education or organization. Where would the medical profession have been today had we not been organized?

Membership in the Association

The very large majority of our members belong to some social or fraternal organization or both, paying ten to one hundred or more dollars a year dues; or they are addicted to golf, poker, or some diversion, which is right, they should be. The point, however, is the dues paid the really important organization for them is in all probability the least expense of any, but is usually paid late and grudgingly. Many of our members belong to special societies, paying twenty-five to one hundred dollars entrance fee and twenty-five to fifty dollars dues, and frequently never attend a meeting of the society and receive nothing but the honor (?) of membership. Our dues now, seven dollars a year, less than a two-cent postage stamp per day, for which we receive a medical journal, medical defense, legal medical advice, membership in the American Medical Association and other benefits too numerous to mention, are so ridiculously low that instead of a secretary having to dun us for weeks we should pay ahead of time and with a smile.

We have lost four per cent of our membership this year. Some of this loss has been legitimate, but the most of it has been inexcusable. As an example, I mention the fact that one of the younger men who had not paid his dues, and whose pleas of poor collections caused the secretary to be lenient with him, calmly and complacently lost thirty-five dollars at a friendly poker table; yet he could not give a postage stamp daily to his society!

I want to drop this seed into your mind with the hope it will take root and grow—two dollars a month, less than seven cents a day, half of or less than you pay for tobacco, beer, candy or any nonessential each day, will bring membership in your local and state societies with their benefits and membership and fellowship, including the American Medical Association *Journal* and other benefits, and give the state association enough funds to put on two high class postgraduate courses a year. Think of that!



ABOUT THE FRENCH LICK SESSION

Schaible, of Gary, was the proudest man at the smoker, walking off with a silver service that required extra help to tote; he was a beaming picture as he stepped from the dais after having been awarded the prize for something or other he had accomplished on the golf course. Gosh, we wish we played golf!

* * *

The golf prizes were all caged up and on display in the hotel lobby. The golf committee sure did itself proud in arranging such a diversified list of prizes. Dr. A. P. Hauss, of New Albany, was responsible for this committee. Fifty-three beautiful prizes were donated by various companies.

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One of the advantages of French Lick as a convention point lies in the fact that everything is under one roof, except the famous spot known as "Brown's." There is little else outside the hotel proper which makes for a successful convention.

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One of the busiest fellows of the convention was Mitchell, the general director of the county society secretaries. "Mitch," always ubiquitous, ran true to form and managed to get in on the "treasure hunt."

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The Thumb-bit stag dinner was a wow! For originality Manager Fawcett takes first prize. Dining off Pluto boxes, using aprons as napkins while enjoying some hot vaudeville acts, proved a most diverting evening. In some twenty-five years of stag entertainment we do not recall one better. "Bill" Kennedy, chairman of the executive committee, ran afoul of a recently extracted molar and had to go on a diet. He concocted some unusual treatment for same, which may later appear in The Journal.

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Among suggestions made at a meeting of the executive committee was that of having county health officers make monthly reports to the county medical societies. This has several advantages. It will keep the local man in touch with local health conditions. The reports need not be complete detailed reports.

* * *

Mrs. George Dillinger, wife of the general arrangements chairman, deserves the highest praise for the manner in which she looked after the entertainment program for the ladies present. There was no occasion for any feminine member to want for something to do. Practically every waking moment was occupied by the participants in her delightful program.

Mickey McCarty, assistant manager and editor of the Indianapolis *News*, asked to send a representative to the convention, responded by sending what he termed a "cub" reporter in the person of William Herschell. "Bill" was the life of the party; his quips fell fast and furious and one was put to it to keep apace.

* * *

The entrance of Governor and Mrs. McNutt on Monday evening added much zest to an already replete program. They at once became engrossed in the dance program in the hotel lobby and were, of course, the center of interest. Mr. Taggart soon appropriated the gubernatorial party and undoubtedly some great questions of state were discussed.

* * *

Without doubt the best part of the stag entertainment was the "fan dance" as interpreted by Bill Herschell of the Indianapolis *News*. Sally Rand, once she escapes the sentence imposed by the Chicago court, must look to her laurels. The late Florenz Ziegfeld, had he seen "Bill" perform, would have been impelled to write a scenario featuring the act.

* * *

A new face appears on the editorial board. Dr. L. P. Harshman, of Fort Wayne, has been secured to succeed Dr. C. N. Combs of Terre Haute. Dr. Harshman is an experienced and most pleasing writer, and from his pen may be expected some interesting material for The Journal.

* * *

As might be expected in an American plan hotel, there was an almost universal complaint of overeating. However, with Pluto, Bowles, and Persepine springs near at hand, and a complimentary package of French Lick salts in every room, a good time was had by all.

* * *

In addition to his accomplishment as a most expert roll-caller, long meter style, George D. Miller has an added laurel—that of finish judge of an excellent "hoss race." When it comes election time in the House said George is in his element; if he gets as much pleasure out of the next session of the Indiana Legislature as he did from this one House session, then George is in for sixty days of unalloyed joy.

* * *

The midnight warblers from down Indianapolis-way failed to put on their annual show, it seems. It may be that they decided to carry on their show in the valleys of the Cumberland Foot Hills. We do recall hearing some discordant notes, seeming to emanate from the far-off dales; we attributed those to a mess of wild cats.

Walter Leach, of New Albany, will guide the destinies of our Association during 1935. We have intimately known Walter for some twenty-five years and have every confidence in his ability as a pilot.

* * *

Morris Fishbein, genial and non-hirsute editor of the *Journal of the A. M. A.*, took advantage of his invitation to speak at the annual banquet to get in a little vacation. He remained at French Lick after the convention for a few days of golf.

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We are glad to note the return of Drs. Cameron and Crockett as A. M. A. delegates. Our experience is that as long as our delegates function efficiently they should be returned. Indiana has every reason to be proud of her present delegation.

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1934 will see us back in Indianapolis where the attendance always reaches a high peak. However, we are strong advocates of the occasional hegira into other sections of Indiana; it surely does provide a local stimulus.

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Hoosier laundries should welcome this session of the Indiana State Medical Association. What with changing one's linen two and three times daily the laundry bags of those attending the convention should be a pleasing sight to laundry drivers in various sections of Indiana.

* * *

The golf addicts reached their seventh heaven, the "Hill" course offering what is probably the sportiest course in these parts. Some of the old stagers admitted a bit of fatigue after a half day of hill climbing, yet many went in for another round in the afternoon.

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The acoustic properties of the main dining room proved very poor and the economic round-table conference was forced to adjourn to the convention hall. The only speaker able to get his message over in the dining room was Governor McNutt, whose voice carried to every corner.

* * *

Dr. Walter L. Bierring, president-elect of the American Medical Association, received a reception that must have warmed the cockles of his heart as he was presented to the House of Delegates in session on Wednesday morning. From a rather intimate acquaintance with Dr. Bierring during our years on the State Medical Board we may say that we expect big things of him during 1935.

* * *

We suggest a bit more care in the selection of delegates to our convention; men should be named who are most certain to attend. Our personal experience in trying to fill a delegation at the unholy hour of six a. m. calls forth the observation that the task is an onerous one. In addition one gets himself disliked calling men at that hour!

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For hypsometrical reasons the attendance was below the usual mark. (Mr. Webster will gladly render his services in the interpretation of this, if needed!)

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More than the usual number of complaints were heard concerning the time of meeting, due to weather conditions. At times the heat and humidity were a bit more than uncomfortable. It is hoped that the executive committee may select a later date for the annual meeting.

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Walter Ford has gathered together an orchestra of unusual merit, which tickled the palates of music lovers at the convention. Disdaining modern jazz, he carried his group through many of the old classics, with an occasional ballad of bygone days, much to the delectation of a large group of admirers.

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As usual the registration desk functioned one hundred per cent. The headquarters staff was on the job and carried on with the utmost precision.

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Over in the Council meeting John H. (Bunny) Hare made a strenuous objection to a pronouncement of Chairman Alexander when he announced "We will now proceed with the *re-election* of so-and-so" (naming one of the important officers).

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Dr. Franklin S. Crockett, of Lafayette, was the recipient of the coveted certificate of appreciation for his work as president of our Association in 1932. The certificate was presented by Dr. Weinstein at the annual banquet on Wednesday evening.

* * *

Mystery field day, tea at the Taggart home on Mt. Airie, with Miss Taggart, Mrs. Paul V. McNutt, and Mrs. J. H. Weinstein as hostesses, dinner in the evening and Minna Schmidt's "Pageant of the Bridal Dress," kept the ladies busy on Monday of the session. Every minute was thoroughly enjoyable. On Tuesday the trip through the Pluto Bottling Plant, luncheon, a visit and tea at Spring Mill Park, a theater party, dancing, and cards prevented any visiting lady from having a dull moment. Luncheon bridge with a book review presentation by that entertaining personality, Kathryn Turney Garten, and the grand finale of the annual banquet completed the entertainment for the ladies on Wednesday. The guests at the French Lick convention were lavishly entertained, and under the able direction of Mrs. George Dillinger everything was carried out smoothly, efficiently, and to the thorough pleasure of all who participated.

FIRST STATE FAIR EXHIBIT

"A successful experiment which should be repeated next year" is the general reaction to the first annual "Good Health" exhibit that was held under the direction of the Indiana State Medical Association during State Fair Week in Indianapolis, September second to eighth. Six of the leading health agencies of the state co-operated with the State Association to make the scientific and educational exhibits housed in the "Good Health Building" on the Fair Ground one of the outstanding features of this year's fair. The purpose of the displays was to show the public the methods and ideals of scientific medicine and its related branches. It is estimated that 25,000 persons visited the exhibit during the week.



Taking Blood Pressures at the State Fair Exhibit.

Under the direction of the Indiana State Dental Society, "Jimmy Chew," the famous dental puppet show, imported especially for the occasion from the Century of Progress Exposition in Chicago, drew some nine thousand spectators as a total of its three daily performances throughout the week.

The Indiana Hospital Association, the Indiana Tuberculosis Association and the Indiana Pharmaceutical Association all had interesting and elaborate displays, and the Indiana State Nurses' Association was in charge of the children's playgrounds adjacent to the State Board of Health and the Good Health Buildings.

High blood pressure was the primary point of emphasis of the combined exhibits of the American Medical Association and the Indiana State Medical Association. Through the courtesy of the Taylor Instrument Company, of Rochester, New York, a new type Tycos self-recording sphygmomanometer was obtained and over 2,500 blood pressures were taken. Three times as many tests could have been run with additional equipment, as interest was very great in the procedure and there always was a crowd around the machine. Each visitor tested was allowed to keep his chart, and in the event that the blood pressure was abnormally high it was suggested that he call upon his family physician and show the chart to him. Tact was exercised not to alarm any person, but in these instances the family physician was notified of the person's name and the pressure obtained.

An excellent array of pathological specimens obtained from the medical school was exhibited. These specimens showed the changes which occur as a result of neglected high blood pressure.

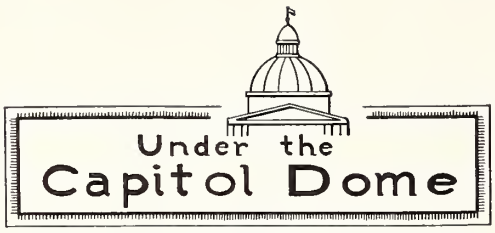
The remainder of the space in the exhibit was devoted to displays concerning patent medicines and quackery and the dangers of self-diagnosis. Some forty posters were shown bearing the names and descriptions of many popular nostrums. Twenty different pamphlets dealing with various types of quackery were available and were eagerly read by the visitors who filled the booth most of the time.

A space was devoted to the health magazine, *Hygeia*, and visitors were informed as to its interesting and educational articles which discuss health problems.

Dr. Russell Sage, of Indianapolis, chairman of the exhibit; Dr. R. L. Sensenich, of South Bend; Dr. J. E. Ferrell, of Fortville; Dr. Gordon Batman and Dr. Thurman B. Rice, of Indianapolis, were present at the exhibit during their allotted time and gave very valuable assistance and suggestions. Two medical students, Oren Kay and Hugh Martin, operated the blood pressure machine and kept accurate records of every case.

Some interesting statistics were obtained: The average State Fair visitor during the last days was 41.2 years of age, weighed 153.9 pounds, and had an average blood pressure of 145.9 systolic and 91.2 diastolic. These figures represent a composite picture of the 2,500 blood pressures taken. The highest systolic blood pressure was 320, lowest systolic blood pressure was 90. The highest diastolic blood pressure was 175, the lowest diastolic pressure was 50. Blood pressures taken during the four days are somewhat above the average, probably because of the exercise and excitement incident to attending the State Fair. The oldest person whose blood pressure was taken was eighty-five years of age, the youngest was four years. The largest person weighed 275 pounds, the smallest weighed forty pounds.

Appreciation is expressed to the State Board of Agriculture for its courtesy in assigning the building to the Indiana State Medical Association and allied societies for this exhibit.



Dr. B. D. Harrington, a graduate of the University of Minnesota, passed the June examinations with the highest grades. He made 906 points out of a possible 1,000. Dr. Harrington has been roentgenologist at the Methodist Hospital in Indianapolis for the past six months. Second highest grade was made by Dr. B. D. Rosenak, a graduate of Indiana University. Dr. Rosenak made 904 points of the possible 1,000.

* * *

A total of 111 candidates successfully passed the June examination for licenses to practice medicine, and three for licenses to practice osteopathy. Nine applicants also were given examinations in the basic sciences. Six applicants for medical licenses failed to pass the examination.

* * *

Offices of the State Board of Medical Registration and Examination have been moved from the third floor of the State House to No. 5, State House Annex, Senate avenue and Market street, across the street from the State House. Offices of the Nurses' Registration Board also were moved to the same headquarters in the Annex.

* * *

Miss Ruth V. Kirk, of Indianapolis, recently became clerk of the Medical Board. She succeeds Miss Mildred Kosanke. Miss Kirk, who had been secretary to Frank N. Wallace, state entomologist, and Miss Kosanke exchanged positions in the shift.

* * *

Dr. W. R. Davidson, of Evansville, is again secretary of the State Board of Medical Registration and Examination. Recently Dr. Davidson resigned from the board. He then was re-appointed by Governor Paul V. McNutt and was re-elected secretary by the board at its last meeting.

* * *

"A decision of outstanding importance to the over-burdened taxpayer of real estate in Indiana was that recently rendered by Judge Sumner Kenner, judge of the Huntington Circuit Court, who in a very able opinion in the case of William D. Hamer versus Claude Wise, held the general intangibles law of Indiana, recently enacted by the Indiana legislature, as constitutional," Philip Lutz, Jr., attorney general, said in a statement for this medical journal.

"Inasmuch as Judge Kenner is the first judge to rule upon this first new law, his decision is considered as highly important to the program for tax reform as fought for by the taxpayers of Indiana who have been interested in relieving real estate of a burden which they were no longer able to bear.

"If the law is sustained in the Supreme Court, as I am sure it will be, Indiana has made an advance in tax legislation that will be a copy book for other states. For years it has been urged that it has been impossible under our Constitution to enact and enforce laws classifying property that would be subject to a lower rate of taxation.

"I believe that we have enacted a law that will meet the test of the courts. If this law is sustained, it will attract millions of dollars of intangible property to our state. It will put millions of dollars of hidden intangibles upon the duplicate that now escapes any share of tax burden. It will cause wealthy residents of other states to locate here for the purpose of securing the benefits of our low rate of taxation upon intangible property, but most important of all, it will relieve a burden from our real estate which has heretofore been the subject of confiscation by unbearable taxes. I believe this law will make desirable the ownership of real estate for investment purposes and will have the effect of raising values from the low depths into which real estate has fallen. Indiana will then be a desirable state to live in and not one to come from."

* * *

Philip Lutz, Jr., Indiana's attorney general, has issued an official opinion that holds that both physicians and chiropractors may practice podiatry without a license from the state board of podiatry examiners. The opinion was written in response to a question submitted by Dr. Dan Tucker, president of the podiatry board. In reaching his conclusion that chiropractors could practice podiatry without a license to do so, the attorney general said: "A chiropractor is a practitioner of medicine and must have a license and is governed by the same statute which covers the practice of medicine generally; the statute defining podiatry requires every one to have a license to practice this profession except physicians licensed by the state board of medical examination and registration, and, therefore, since a chiropractor is licensed to practice medicine under the provisions of the statute, he would have the right in my opinion, to practice podiatry under the expressed provisions of this statute."

* * *

Licenses of two practicing physicians have been revoked recently by the State Board of Medical Examination and Registration. They were Dr. Walter M. Roland of Connersville, and Dr. John R. DeRoahn of Indianapolis. Both were convicted of felonies.

One of the state medical board's own rulings got the board members into a quandary last month, and the board was forced to ask the attorney general to help. A ruling of the board was issued some time ago to comply with a standard of education for licensure adopted by the committee on Medical Education of the American Medical Association, the Association of Medical Colleges and the Federation of State Boards. This rule provided that the minimum time should be four courses in a recognized school, and that forty-two months should elapse between matriculation and graduation. But the Rush Medical College, University of Chicago, has its course arranged in the quarterly system and requires at least three quarters per year shall constitute a course. This arrangement would allow a student to complete his required work in forty to forty-one months. With graduates of Rush among those taking the recent examination, members of the board did not know what to do about those who had successfully passed the examination. Attorney General Lutz ruled that in the case of a recognized medical college the fact that forty-two months did not elapse between matriculation and graduation would not in itself prevent the board from issuing a certificate to its graduates.

* * *

Bad tastes and pollution to be found in Lake Michigan are not all due to lack of sewage treatment and recovery plants in Lake County, but are in a measure originating in Illinois, L. A. Geupel, chief engineer for the state division of public health, has informed Governor Paul V. McNutt.

Mr. Geupel's report was the health division's reply to criticism of Indiana officials and Lake County for conditions said to "originate in Indiana" causing pollution and bad taste in Chicago's water supply drawn from Lake Michigan.

Attention was called by the engineer to the fact that the health division of Indiana has been working on the Chicago complaints since they first were seen in newspaper clippings in February and that several important conferences have been held since then. An outgrowth of the conferences has been the beginning of chemical analysis and appeals to Lake County industries and cities.

Mr. Geupel's report confessed that the Grand Calumet river in Lake County probably is the "largest puddle of pollution in the world" and that the cities of Gary, Whiting, Hammond, East Chicago, East Gary, Hobart and Chesterton have not expended any funds in the construction of sewage treatment works. Sewage from these cities is treated only with chlorine after it is diluted with lake water and pumped back as a fresh water supply. However, the report said, Illinois steel companies are contributing their share to the lake pollution. The engineer recommended construction of plants to eliminate the pollution, and said that such plants could be built through funds obtained from the Reconstruction Finance Corporation.

SECRETARIES' COLUMN

The exhibits of the Indiana Division of Public Health, the Indiana State Medical Association and others at the State Fair were highly successful. Attendance at these exhibits indicate that the people of Indiana want health education. Now it is up to the county medical societies to provide such health education for the people in their respective counties.

A short time ago in this column I told you about a baby show in Terre Haute. The medical society was asked not to take any part in this show, and the Vigo County Medical Society was one hundred per cent in refusing to have anything to do with it. They did get one doctor, who advertises in the newspapers, and one other doctor to do this work. After the show was over someone telephoned my office and said, "In spite of Dr. Mitchell and his medical society we had a baby show, and it was a success." I am happy to say that the members of the Vigo society believe in organization.

According to the September issue of the *Forty and Eighter* three hundred children in Shelbyville have been immunized against diphtheria. I hope that this was sponsored by the county medical society. Wonder if all the children were indigents?

Whenever you give a patient a sample of medicine, remove the labels; if you don't, you will surely lose some business.

I know a physician who had a call to another city which almost put him "on the spot." First a stock market racket was tried on him, and failing in that the perpetrators tried to make him "fall" for a violation of the Mann Act. Beware of the racketeer!

Is there any way to get to the advertisers of fakes and nostrums over the radio? Won't someone send in suggestions? The public needs more education. The NRA code for retail druggists has a wonderful clause on this subject.*

All the medical societies in the state should follow the suggestions in the A. M. A. *Journal* about the NRA. Let all physicians adopt the blue eagle with the word "Consumer" and not humiliate any physician because he can not financially have a blue eagle with the word "Member." Let all physicians back up the NRA. Give it a trial; if it is found wanting, we probably will be no worse off than we were!

A. M. Mitchell, M. D., *Chairman.*

* *Journal* A. M. A., September 9, 1933, page 856.

DIPHTHERIA REPORT FOR AUGUST, 1933

We are gratified to be able to report that there were only four deaths from diphtheria during the month of August; two from Allen County, one from Greene County, and one from Madison County. Allen County had already had seven deaths, now making a total of nine. This places Allen County far above any other county in the state in diphtheria death rate.

The author of this column calls attention to the fact that he has warned Allen County almost every month for the past two years that it was in the midst of an epidemic, which should be controlled in a community as progressive as Allen County claims to be. One-half of all the deaths for the month of August over the entire state were from that one county, and approximately one-sixth of all the deaths so far this year over the entire state were from that one county.

The total number of deaths so far this year is considerably under that for the corresponding period of last year, and we are hoping that we shall be able to set up a new low record for 1933. There will, however, be a close race with the years 1930 and 1931. We must not forget that the diphtheria season is just ahead—October, November and December. As soon as the school begins, diphtheria begins. Physicians and health officers cannot be too careful with suspicious throats at this time of the year.

A list of counties indicating the number of deaths for the month of August, and for the year to date is given below:

County	Total for 1933	August, 1933
Allen	9	2
Bartholomew	1	0
Blackford	1	0
Daviess	2	0
Delaware	1	0
Dubois	1	0
Fayette	1	0
Fulton	1	0
Greene	2	1
Hancock	2	0
Harrison	1	0
Howard	1	0
Jackson	2	0
Knox	1	0
Lake	2	0
Lawrence	2	0
Madison	1	1
Marion	8	0
Monroe	1	0
Morgan	1	0
Noble	1	0
Orange	1	0
Parke	1	0
Pike	1	0
Randolph	1	0
Ripley	1	0
Shelby	2	0
Starke	1	0
St. Joseph	1	0
Sullivan	3	0
Switzerland	1	0
Tippecanoe	3	0
Union	1	0
Vigo	1	0
Warrick	1	0
Warren	1	0
Wayne	1	0
Wells	1	0
Vanderburgh	1	0
	65	4

VOICE OF THE DOCTOR

BRIEF OF RELATIONSHIP OF VIGO COUNTY TO RILEY HOSPITAL

Vigo County pays a per diem charge to Riley Hospital, which averaged $3.08 during 1932, paid by the auditor out of an appropriation for state institutions, which was approximately $18,000 in 1932.

The number of patients receiving bed care in Riley Hospital in 1932 was 19. Out-patients of Vigo County in 1932 were 21, with 63 visits.

The procedure for sending cases to the Riley Hospital is an examination by a physician, who reports to the Circuit Court, and the Circuit Court commits the patient to the hospital. For this the doctor is paid $3.00 and a clerk $5.00. The patient is sent to Indianapolis at the expense of the county at an estimated average cost of $17.50.

For out-patients the charge is 60 cents when only seen at the hospital.

The number of hospital days charged for by Riley Hospital during 1932 was 1,310 days for 19 patients. The cost per patient during 1932 was $205.91. With the expense of trips to Indianapolis added to this, the cost per patient would be $261.03.

The total amount paid Riley Hospital by Vigo County during 1932, for hospital days, splints, etc., was $4,959.59.

If these patients, with 1,310 hospital days, had been sent to the Terre Haute hospitals, the cost would have been $3,275.00, a saving of $1,684.59. This is exclusive of the cost of transportation to and from Indianapolis, also the extra days in the hospital necessitated by transportation back and forth.

The law at the last legislature was changed in that it gives Vigo County and its judge the right to send cases to their home charity institutions in the same manner we send them to Indianapolis.

A survey of Union Hospital shows that from

September 1, 1931, to September 1, 1932, 44 crippled children, with 939 days, were taken care of. There is every reason to believe St. Anthony's Hospital took care of fully as many as Union Hospital during this time. The cost of these cases according to the Riley Hospital charge would have been $2,892.12. The hospitals of Terre Haute have always stood ready, and do today, to accept these cases at a per diem charge of $2.50.

Vigo County has been paying Riley Hospital more per year to take care of a limited number of crippled children than it has been giving both of our hospitals to take care of all their charity cases. The hospitals in Terre Haute have been taking care of more crippled children than Riley Hospital with no charge whatever.

The hospitals propose and the doctors of Vigo County agree that the crippled children from Vigo County should be sent to our own hospitals and paid for in the same way that Riley Hospital is paid. Our hospitals are perfectly able to give the same treatment and at a saving of more than $2,000.00 per year.

It will be necessary for the proper authorities to make an appropriation for the care of crippled children instead of putting this under a blanket appropriation for state institutions. Then the judge can commit them, under the law, to our home institutions the same as Riley Hospital. We have every reason to believe that the circuit judge will do this when the appropriation is made in the proper way so that he can lawfully do it.

Union Hospital, during 1932, cared for 443 different charity patients, with a total of 4,130 nursing days. At the Riley rate of $3.08 per day the cost would have been $12,720.40. While the St. Anthony's Hospital records have not been gone through, their number of charity cases is fully as large, if not larger. This added to Union Hospital and at the Riley Hospital charge would make $25,440.80.

The county pays each hospital $2,000 per year.

There is no contention that Riley Hospital is not a necessary and worthy institution, but we are convinced it should be used by counties who do not have the proper hospitals or the proper facilities to take care of their crippled children.

The Medical Committee stands ready to verify each of these statements whenever it is desired.

DEATH NOTES

Theodore David, M. D., Negro physician of Indianapolis, died August twenty-second, aged twenty-eight years. Dr. David graduated from the Indiana University School of Medicine in 1929.

O. L. Stout, M. D., of Upland, died August thirteenth, aged sixty-nine years. Dr. Stout served several terms as coroner of Grant County. He graduated from the Kentucky School of Medicine, Louisville, in 1881.

W. H. White, M. D., of Amo, died August twenty-sixth, aged eighty years. Dr. White was a graduate of the Medical College of Indiana, Indianapolis, in 1882.

Burton O. Post, M. D., of Sulphur Springs, died September first, aged sixty-eight years. Dr. Post was prominent in his community and for many years was president of the Peoples Bank of Sulphur Springs. He graduated from the Medical College of Indiana, Indianapolis, in 1882.

Frank Edward Abbett, M. D., of Indianapolis, died September seventeenth, following an illness of only a week. He was fifty-two years of age. Dr. Abbett once served on the staff of the Indianapolis City Hospital, and was head of the medical staff of the Florence Crittenton Home. He graduated from the Medical College of Indiana, Indianapolis, in 1905.

P. G. Fermier, M. D., of Leesburg, died September nineteenth as the result of injuries received when he was struck by an automobile. Dr. Fermier was sixty-seven years of age. He had been county health officer for Kosciusko County for many years, and was a member of his county medical society, the Indiana State Medical Association, and the American Medical Association. He graduated from the Medical College of Indiana, Indianapolis, in 1894.

HOOSIER NOTES

Dr. H. W. McKane has opened an office in Columbus, where he will practice medicine.

Members of the Rush County Medical Society met at Rushville, September twelfth.

Dr. Arnold L. Lieberman, of Gary, and Miss Hilda Kahan, of Gary, were married August twenty-seventh.

Members of the Spencer County Medical Society met at the home of Dr. Claude Lomax at Dale, Indiana, September twelfth. Guest speakers were Drs. John Hare and O. C. Stephens of Evansville. A banquet followed the meeting.

MEMBERS of the Orange County Medical Society met at the home of Dr. and Mrs. G. G. Colglazier, in Leipsic, September fifth.

DR. PAUL D. WILLIAMS, of Monticello, has received an appointment to the staff of Longcliff, the State Hospital at Logansport.

DR. ARTHUR N. FERGUSON, of Chicago, has joined the staff of the Duemling Clinic at Fort Wayne as diagnostician and internist.

MISS VIRGINIA DROZ and Dr. Arthur W. Kistner, of Elkhart, were married at Washington, Iowa, September second.

DR. FERNANDA H. LUCK, of Bloomington, has been appointed physician for the Woman's Prison in Indianapolis. Her duties began September first.

MEMBERS of the Huntington County Medical Society met September fifth at the Hotel Lafontaine in Huntington. Dr. Karl M. Koons, of Indianapolis, presented a paper on "Goiter."

THE Shelby County Medical Society held its first fall meeting at the Blue River Country Club, Shelbyville, September sixth. Dr. J. H. Stygall, of Indianapolis, was the principal speaker.

THE Society of Plastic and Reconstructive Surgery will hold its annual meeting October sixteenth, seventeenth and eighteenth in New York City. Members of the medical profession are invited to attend.

DR. CHARLES P. EMERSON, of Indianapolis, talked to members of the Jay County Medical Society at the Portland Country Club, September first. His subject was "Medicine in the Orient."

DR. HERMAN L. KRETSCHMER, of Chicago, was the principal speaker before the members of the Elkhart County Medical Society, at Elkhart, September seventh. Attendance numbered forty.

AT the Indiana State Conference on Social Work, October third to fifth, in Indianapolis, with headquarters at the Claypool Hotel, Dr. Joseph H. Weinstein, president of the Indiana State Medical Association, and Dr. H. E. Chamberlain, of Chicago, will be speakers. Dr. Chamberlain is associate professor of psychiatry in the University of Chicago and is a director of psychiatric studies of delinquent children in a joint project supported by the Chicago School of Social Service Administration and the United States Children's Bureau.

MEMBERS of the Kosciusko County Medical Society met at the Hotel Hayes, Warsaw, September twelfth. Drs. C. N. Howard and C. E. Thomas presented a discussion of a recent case of encephalitis.

TRIBUTE will be paid Dr. Walter Reed, discoverer of the yellow fever germ, during the annual session of the American Public Health Association which will convene in Indianapolis, October ninth to eleventh.

MEMBERS of the Wayne-Union County Medical Society met at the Richmond-Leland Hotel, September fourteenth, for a dinner meeting. Dr. Clifford Straley, of Cincinnati, Ohio, was the principal speaker.

THE Fort Wayne Medical Society installed its new officers at a meeting held in the Chamber of Commerce, September fifth. Dr. A. L. Mikesell is president; Dr. W. B. Rice is vice-president; and Dr. L. P. Harshman is secretary-treasurer.

THE American Academy of Ophthalmology and Otolaryngology met in Boston, September eighteenth to twenty-second, with headquarters at the Hotel Statler. A number of Indiana members attended the meeting.

THIRTY-TWO physicians attended the meeting of the Gibson County Medical Society at Princeton, September eleventh. Dr. A. M. Mitchell, of Terre Haute, and Dr. O. O. Alexander, of Terre Haute, were the principal speakers.

DR. MORRIS C. THOMAS has been granted a license to practice medicine in Carroll County. Dr. Thomas has taken over the practice of Dr. John Flora, of Flora. Dr. Flora expects to spend two years in the east, where he will do postgraduate work.

A TWENTY-FOUR-HOUR service to handle emergency calls of the State Division of Public Health was inaugurated recently, according to an announcement of Dr. Verne K. Harvey, department director. The plan provides for two students from the Indiana University School of Medicine to be on duty during the night, to receive calls and to keep in contact with health officers.

The Lake County Medical Society held its first meeting of the fall and winter season at St. Margaret's Hospital, in Hammond, September fourteenth. This was "Indiana University Night" with the program provided by members of the teaching staff of the Indiana University School of Medicine.

Members of the Tippecanoe County Medical Society met at Lincoln Lodge, September fourteenth, to hear Dr. Max A. Bahr and Dr. W. L. Breutsch, of Indianapolis, discuss "Epidemic Encephalitis" and "Parkinsonism." Fifty members enjoyed the dinner and one hundred attended the meeting to hear the addresses.

The Hancock County Medical Society held its regular meeting at the Columbia Hotel in Greenfield, September eleventh. A symposium on "Pulmonary Tuberculosis as the General Practitioner Sees It" was presented by Drs. C. E. McCord, S. W. Hervey, J. E. Ferrell, B. Deakyne (dentist), and Stewart Slocum, all of Fortville.

The 1934 annual meeting of the Second District Medical Society will be held at Sullivan. Dr. J. S. Brown, of Carlisle, and Dr. H. C. Wadsworth, of Washington, were re-elected secretary and councilor. The new president will be selected by the local medical society of the city selected for the next meeting.

Medical reserve officers in the Indiana military area are invited to attend a state dinner at the Columbia Club, Indianapolis, October fourteenth. Guests will be Secretary of War Dern, Major-General Mosely, United States senators and congressmen, and others. Detailed information may be obtained from Lieutenant-Colonel F. L. Hosman, M. D., 1505½ N. Illinois St., Indianapolis.

In addition to the articles already enumerated the following have been accepted:

U. S. Standard Products Company—

Antimeningococcic Serum Polyvalent, 30 cc. vial package.

Diphtheria Toxin-Antitoxin Mixture, 0.1 L, 10 cc. vial package.

Rabies Vaccine—U. S. S. P. (Semple Method), 7 syringe packages.

Rabies Vaccine—U. S. S. P. (Semple Method), 14 vial packages.

The annual meeting of the Seventh District Medical Society will be held at Plainfield, October twentieth, at two-thirty in the afternoon. Dr. T. J. Beasley is president of the society; Dr. M. V. Pitkin is vice-president, and Dr. W. L. Portteus is secretary. The program for the meeting is as follows:

"The Use of Selective Autogenous Vaccine in the Treatment of Bronchial Asthma." By Thomas J. Beasley, M. D., Indianapolis.

"The Relief of Obstinate General Edema by Use of Subcutaneous Drainage Tubes." Case report and description of method used. By E. Ray Royer, M. D., North Salem, Indiana.

"Pyrogen Treatment of General Paresis." By H. M. Banks, M. D., Indianapolis.

"Transurethral Removal of Bladder Neck Obstructions." By P. E. McCown, M. D., Indianapolis.

"Angina Pectoris." By George F. Bond, M. D., Indianapolis.

"Pellagra in Indiana and Its Treatment." By Paul J. Fouts, M. D., Indianapolis.

Following the dinner, Dr. Plinn F. Morse, of Harper Hospital, Detroit, will present a paper on "Parathyroid in Its Relation to Clinical Medicine."

INDIANA UNIVERSITY NEWS NOTES

Approximately 150 physicians attended the annual meeting of the Second District Medical Society held at Indiana University, Wednesday, September thirteenth. The day's program was devoted to child welfare and maternity work as part of the work of the state medical society under auspices of the I. U. School of Medicine, which has taken over this division of the state health department.

The meeting opened with registration at 11 a. m. in Owen Hall, I. U. Medical School Building. A luncheon was served at noon in the I. U. cafeteria and the official program began at 2 p. m. in the auditorium of the I. U. Chemistry Hall. Dr. R. H. Pierson, Spencer, presented and discussed a case of erythroedema. This was followed by a case report and discussion of encephalitis by Dr. M. S. Brown, of Spencer, and Dr. L. T. Meiks, Indianapolis. Dr. F. H. Austin, Bloomington, then spoke on "Use of Atropine in the Treatment of Children," and Dr. J. E. P. Holland, also of Bloomington, presented a paper on "Syphilitic Keratitis in the Young." This was discussed by Dr. Byron K. Rust, Indianapolis. Dr. Matthew Winters, Indianapolis, spoke on "Prevention of Communicable Diseases." The business meeting of the Association followed Dr. Winters' address.

The annual dinner of the Second District was held at the Graham Hotel Rathskeller at six p. m. that evening. The evening session, held in the high school auditorium, was open to the public. It included a discussion of "Aspects of Child Engineering," by E. L. Yeager of the I. U. Psychology Department, and of "Mental and Physical Hygiene of Infancy and Childhood," by Dr. L. H. Segar, Indianapolis.

Dr. Homer Woolery, of Bloomington, was chair-

man of the program committee, with Dr. Phillip Holland and Dr. Russell DeMotte, also of Bloomington, assisting. Dr. Ray Borland, Bloomington, president of the Second District, presided at the various sessions.

AT the request of the American Medical Association, Dr. Thurman B. Rice of the Indiana University School of Medicine has written a new set of sex education pamphlets to replace an older set published by the Association. In reviewing the new publications the health magazine, *Hygeia*, commends the Association for its selection of Dr. Rice as the author and approves Dr. Rice's "courage to face the fact that modern young people will no longer be satisfied with sophistry when it comes to learning about the processes of procreation. At the same time he has not departed from the fundamental principle that civilization is founded on the home. He has taken the sound position that sex is so deeply interwoven with the mental, moral and spiritual life, as well as with the physical life, that there can be no ignoring or isolating it."

THE three Indiana University hospitals, located in Indianapolis, during the month of July served a total of 1,056 patients according to the monthly report of J. B. H. Martin, administrator of the I. U. hospitals and medical school. Of this number 697 were bed patients confined to the hospitals, while the remaining 359 were out-patients. The James Whitcomb Riley Hospital for Children served 540 patients, the William H. Coleman Hospital for Women 295, and the Robert W. Long Hospital 221 patients. The three I. U. hospitals made 2,170 out-patient visits during July as compared with 2,113 during the same month last year. A total of 8,322 laboratory examinations were made this July, which is 582 more than were made during July of 1932.

UNDER terms of an agreement reached between the Board of Commissioners of Owen County at Spencer, representatives of the James Whitcomb Riley Hospital for Children and the Union Hospital at Terre Haute, free hospital service for numerous Owen County poor children and indigent adults is guaranteed for each year for many years to come without expense to the county or its taxpayers. The arrangement was made possible through the will of the late Miss California Scheil, prominent and generous resident of Spencer, who died in 1930. The arrangement worked out under the will is unique in Indiana history; it becomes effective immediately.

First bequest of the will was for construction and maintenance of a hospital in Spencer for use of Owen County residents, but the commissioners of that county, faced with the necessity of new construction and the heavy cost of maintenance later, could not avail themselves of the bequest. The county, it was decided, could not bear the cost of maintenance. The will provided in the event the hospital was not constructed such funds as were provided should go jointly to the Union Hospital of Terre Haute and to the Riley Hospital. The commissioners, seeking to conserve the benefits of the will for Owen County, found the Riley and Union Hospitals eager to co-operate in carrying out the wishes of Miss Schell—it being her clearly expressed desire that aid be given to poor children through hospital care and to adults not able to pay for hospital treatment. After negotiations a plan was worked out which provides that the sum of approximately $20,000 is to be given to the two hospitals. Each is required to invest the fund in securities approved by the State Banking Department. Each year the income is to be applied on the cost of the care and treatment of patients sent to the hospitals under the present law by the judge of the Circuit Court. This arrangement, under the agreement, shall continue as long as the hospitals continue to operate.

In the case of the Riley Hospital the income from the fund, invested to return four per cent, will approximate the average sum paid by Owen County children in the Riley Hospital. Under present cost the Riley will provide medical care, nursing, food, clothing, instruction and its many other services for 300 patient days or for 30 patients remaining in the hospital for a period of ten days each. "Under this splendid plan the generosity of California Schell will provide the best of medical and surgical care for Owen County children needing help without one cent of cost to the taxpayer or to any individual so far as the Riley Hospital is concerned," said Hugh McK. Landon, chairman of the Riley Hospital Executive Committee. Likewise Miss Schell's generosity applies to the adult poor of her community through the Union Hospital.

The Riley Hospital is greatly pleased to assist in carrying out the provisions of the will and seriously recommends that generously inclined persons elsewhere consider the new plan as an excellent method of providing great benefits for the needy children of other counties in the state.

Each of the hospitals will establish the special trust fund under the name of "The California Schell Memorial Fund."

BOOK REVIEWS

BOOKS RECEIVED

THE DISEASES OF INFANTS AND CHILDREN. By J. P. Crozer Griffith, M. D., Ph. D., Emeritus Professor of Pediatrics in the University of Pennsylvania; Consulting Physician to the Children's Hospital and St. Christopher's Hospital for Children; Consulting Pediatrist to the Woman's, the Jewish and the Misericordia Hospitals, Philadelphia, and A. Graeme Mitchell, M. D., B. K. Rachford Professor of Pedi-

atries, College of Medicine, University of Cincinnati; Medical Director and Chief of the Staff of the Children's Hospital Research Foundation; Director of Pediatric and Contagious Services, Cincinnati General Hospital. 1155 pages with 281 illustrations. Philadelphia and London: W. B. Saunders Company, 1933. Cloth, $10.00 net.

* * *

HISTORY AND EPIDEMIOLOGY OF SYPHILIS. The Gehrmann Lectures, University of Illinois, 1933. By William Allen Pusey, A. M., M. D., LL. D., Professor of Dermatology Emeritus, University of Illinois. 113 pages, profusely illustrated. Cloth. Price $2.00. The Charles C. Thomas Company, Springfield, Illinois, 1933.

* * *

A TEXT-BOOK OF PHYSIOLOGY. By William H. Howell, Ph. D., M. D., Sc. D., LL. D., Emeritus Professor of Physiology in the Johns Hopkins Hospital, Baltimore, Maryland. Twelfth edition, thoroughly revised. 1132 pages with 308 illustrations. Philadelphia and London: W. B. Saunders Company, 1933. Cloth, $7.00 net.

* * *

THE SURGICAL CLINICS OF NORTH AMERICA. (Issued serially, one number every other month.) Volume 13, No. 4. (Mayo Clinic number, August, 1933.) Octavo of 215 pages with 65 illustrations. Per clinic year, February, 1933, to December, 1933. Paper, $12.00; cloth, $16.00 net. Philadelphia and London: W. B. Saunders Company, 1933.

* * *

THE JOY OF LIVING. An autobiography by Dr. Franklin H. Martin. Forewords by Dr. William J. Mayo, Dr. George W. Crile, Newton D. Baker, Secretary of War in President Wilson's Cabinet, and Daniel Willard, former Chairman of the Advisory Commission of the Council of National Defense. Two volumes. Profusely illustrated. Cloth. Price $7.00. Doubleday, Doran and Company, Garden City, New York, 1933.

* * *

INTERNATIONAL CLINICS. A quarterly of illustrated clinical lectures and especially prepared original articles by leading members of the medical profession throughout the world. Edited by Louis Hamman, M. D., Visiting Physician, Johns Hopkins Hospital, Baltimore, Maryland. Volume III, forty-third series, 1933. Cloth. J. B. Lippincott Company, Philadelphia, Montreal and London, 1933.

* * *

HOW TO STAY YOUNG. By Robert Hugh Rose, A. B., M. D., former instructor, Postgraduate Medical School, New York; author of "Eat Your Way to Health." 195 pages. Cloth. Price $1.50. Funk and Wagnalls Company, New York and London, 1933.

* * *

FETAL, NEWBORN, AND MATERNAL MORBIDITY AND MORTALITY. Report of the Subcommittee on Factors and Causes of Fetal, Newborn, and Maternal Morbidity and Mortality. Hugo Ehrenfest, M. D., Chairman. 486 pages. Cloth. Price $3.00. D. Appleton-Century Company, New York City.

* * *

TEXTBOOK OF PHYSICAL THERAPY. By Heinrich F. Wolf, M. D., with a foreword by Lewellys F. Barker, M. D., and chapters by William Bierman, M. D., Adolph A. Lilien, M. D., Farel Jouard, M. D., and Madge C. L. McGuinness, M. D. 409 pages with 54 illustrations. Cloth. Price, $5.50. D. Appleton-Century Company, Incorporated, New York and London, 1933.

* * *

NERVOUS BREAKDOWN. Its Cause and Cure. By W. Beran Wolfe, M. D., Director, the Community Church Mental Hygiene Clinic, New York. 240 pages. Cloth. Price, $2.50. Farrar and Rinehart, Incorporated, New York, 1933.

BOOK REVIEWS

SURGICAL PATHOLOGY. By Wm. Boyd, M. D., M. R. C. P. Ed., F. R. C. P. Lond., F. R. C. S., Professor of Pathology, University of Manitoba; Pathologist to the Winnipeg General Hospital, Winnipeg, Canada. Cloth. 866 pages. Third edition, thoroughly revised, with 477 illustrations and 13 color plates. Cloth. Price $10.00. Philadelphia: W. B. Saunders Company, April, 1933.

In the foreword to this splendid volume, Dr. William J. Mayo says that the need in medical literature today is a work on surgical pathology which attacks the problem from a practical standpoint. The practicing physician can thereby readily acquaint himself with readable material which will help him in his pathology studies. The new material as well as the revised portions make this book a very useful one to have on hand. There is a chapter in particular, the last one, which is called "The Surgeon and His Laboratory," that is unusually good. It deals with the subject of the usefulness as well as the uselessness of the laboratory in its relation to the doctor. The things that a laboratory offers as well as the correct procedures in getting the most from it are given in sufficient detail without confusing statements of technique which belong, in fact, to the technician and not to the practitioner. It is a good book.

* * *

FRONTIERS OF MEDICINE, by Morris Fishbein, M. D., Editor of the *Journal of the American Medical Association*. A Century of Progress Series. 207 pages. Cloth. Price $1.00. Williams and Wilkins Company, Baltimore, 1933.

Morris Fishbein, always a good writer, fairly outdoes himself in this choice bit of chronological history of medicine. Beginning with the history of magic, he carries his reader through a most interesting history of the foundation and the advance of medicine, from the days of Hippocrates and Aesculapius down to the present time. The book is excellently printed, is easily read, and will make a worthy addition to the library of every physician.

* * *

ESSENTIALS OF PRESCRIPTION WRITING. Cary Eggleston, M. D., Assistant Professor of Clinical Medicine, Cornell University Medical College, New York City. Fifth revised edition. 155 pages. Cloth, Price $1.50. W. B. Saunders Company, Philadelphia, 1933.

The new edition of an interesting booklet should serve equally well for the student and the practitioner; we have commonly remarked that prescription writing is becoming a lost art and such a book as this will do much to restore that art if sufficiently read. Well arranged and indexed, it meets the requirements of those who most need such work—the busy doctor.

* * *

HOW LIFE GOES ON AND ON; THE AGE OF ROMANCE; IN TRAINING; THE VENEREAL DISEASES; THE STORY OF LIFE. Sex education pamphlets issued by the Bureau of Health and Public Instruction of the American Medical Association. By Thurman B. Rice, M. D., professor of bacteriology and pathology, Indiana University School of Medicine. Paper covers. Price, twenty-five cents each; complete set of five in special filing case, $1.00. The American Medical Association, 535 North Dearborn Street, Chicago. 1933.

These five pamphlets have been prepared for those who have to do with the training of boys and girls. "The Story of Life" is for boys and girls ten years old; it explains how life is produced as regards plants, animals, and human beings. "In Training" is for boys of high school age, and "How Life Goes On" is for girls of high school age; these books give good reasons for sensible preparation for a satisfactory adult life and will appeal to any fair-minded boy and girl. "The Age of Romance" and "The Venereal Diseases" were prepared for both sexes of college age or older. They are not sensational, but they do explain definitely the things that should and should not be done and, perhaps most important,

the reasons therefor. To those persons who have boys and girls to care for, these five books will be worth many times the dollar paid for them. The physician will be conferring a favor upon the mothers and fathers of his clientele by telling them of these pamphlets. They present hard-to-present subjects in a most satisfactory and useful manner.

SOCIETIES AND INSTITUTIONS

INDIANA STATE MEDICAL ASSOCIATION BUREAU OF PUBLICITY

June 9, 1933.

Meeting called to order at 3:00 p. m.

Present: William N. Wishard, M. D., chairman; E. D. Clark, M. D., and T. A. Hendricks, executive secretary.

Release for publication May 29, Postgraduate Course, Indiana State Medical Association, at Richmond, June 1, approved by bureau individually previous to the meeting.

Release for publication in Saturday morning papers, June 17, "Causes of Illness," read, corrected and approved.

Release for publication June 24, Secretaries' Conference at the Indiana University School of Medicine June 26 on new set-up of State Board of Health. Secretary authorized to prepare release and send it to bureau members for approval.

Radio releases: Saturday, May 13—"Keep Your Eye on the Ball." Saturday, May 20—"Strenuous Week-Ends." Saturday, May 27—"Prevent Hay Fever Now." Saturday, June 3—"Cracked Toes."

Reports on medical meetings: April 6—Fountain-Warren Medical Society, Kingman, Ind. "Medical Economics." April 14—Floyd County Medical Society, New Albany, Ind. "Medical Economics." May 3—Bartholomew County Medical Society, Columbus, Ind. "Medical Economics."

Letter received from the secretary of the State Board of Health enclosing a letter from a woman at Greencastle asking for suggestions concerning the work that may be carried on by the health unit in that community. The Bureau of Publicity instructed the secretary to inform the director of the Indiana State Department of Health that the bureau would be very pleased to do everything it can to aid in this program. The bureau was of the opinion that this matter should be given the fullest consideration and that failure in action would cause criticism. Special effort should be made to afford all information possible and all assistance possible to the local county medical society in aiding it to carry out any program that is approved by the local medical society. The bureau stressed the fact that such work should be done only through a local medical society.

Letter from the Vivisection Investigation League of New York received by the editor of *The Hoosier Sentinel*, Indianapolis, and referred to the bureau. This is the same type of letter that was received last year by the *Plymouth Pilot*, Plymouth, Indiana, in regard to a similar statement by the Bureau of Publicity of the Indiana State Medical Association advocating measures of prevention for typhoid fever. The vivisection league is opposed to the article due to the fact that it advocated anti-typhoid inoculations.

A letter from the secretary of the Vanderburgh County Medical Society was brought to the attention of the bureau. This letter stated that a question had arisen as to whether or not a physician who is making a radio broadcast should be introduced by his name. The bureau made a restatement of the rule governing broadcasting laid down in its annual report to the House of Delegates, September, 1929. This rule follows:

> "The bureau has adopted a rule that no physician who is in private practice should have his name mentioned over the radio in connection with the Bureau of Publicity broadcasts. The names of physicians holding public office and connected with public institutions may be mentioned over the radio."

The bureau feels that the same basis which prompted the adoption of that rule for its own broadcast might well apply to the Evansville case.

The opinion of the bureau was asked as to the advisability of the members of the profession speaking on the majority and minority reports of the Committee on the Costs of Medical Care to the lay public. The bureau feels that the statement made by the president of the State Association in regard to the policy concerning these talks is sound and it wishes to uphold that statement, which is as follows:

> "I still feel that we should definitely stand on the ground that we adopted in regard to lay publicity on the majority report. It is not creating any sensation among the public, and I think we are more likely to bring it to their attention by our efforts of antagonism than by silence. If these civic clubs want the doctors to talk to them on the economic conditions of the medical profession it can be done without bringing in any mention of the majority or minority report, and yet lay before them our position in regard to the care of the indigent, public health and the cost of medical care. Let's discourage this practice as much as possible."

It was with regret that the Bureau of Publicity received a letter in which Mrs. Edna Hatfield Edmondson, the executive secretary of the Indiana Congress of Parents and Teachers, announced her resignation.

The bureau owes a deep debt of gratitude for the splendid help and co-operation received from Mrs. Edmondson in helping to distribute the releases of the bureau to the various local parent-teacher units in Indiana. The secretary was instructed to write to the state president of the parent-teacher association offering the services of the bureau and asking for details in regard to a plan for continuing distribution of its articles through parent-teacher organizations.

June 27, 1933.

Meeting called to order at 3:00 p. m.

Present: William N. Wishard, M. D., chairman; J. H. Stygall, M. D.; E. D. Clark, M. D., and T. A. Hendricks, executive secretary.

Release for publication June 23, Secretaries' Conference at Indiana University School of Medicine—new set-up of State Board of Health, approved by bureau individually previous to the meeting.

Release for publication in Monday morning papers, July 3, "July Fourth Injuries," read, corrected and approved.

Radio releases: Saturday, June 17—"Causes of Illness." Saturday, June 24—"Safe and Sane Swimming."

Report on medical meeting: May 3—Lawrence County Medical Society, Bedford, Ind. "Various Plans of Medical Poor Relief."

Letter received from the secretary of a county medical society, which reads as follows:

> "I have been intensely interested in the articles in the State JOURNAL on the fight on state medicine and have talked in the society meetings about it, and I have insisted on the members reading them. Would you please tell me just what they expect of us or, better still, could you meet our society sometime in the near future and give us a talk along the lines as outlined in THE JOURNAL so that we may make arrangements to carry on our part of the program in accordance with the wishes of the State Society?"

Letter answered stating that if the time and place were set the officers of the State Association would be glad to attend the meeting.

Historical material in regard to Wabash and Hendricks counties forwarded to the historian of the Association and letter of acknowledgment received from historian. If any one in the state has any material in regard to the practice of medicine in Indiana which would be of historical interest the Bureau of Publicity of the State Association requests that such material be sent to it and through the bureau it will be forwarded to the historian.

A letter was received from a physician in Indiana concerning offers of druggists to allow rebates on trusses or similar garments. The Bureau of Publicity authorized the secretary to send the following answer to this letter:

"Your letter of June 17 to Dr. Wishard was referred to the Bureau of Publicity of the Indiana State Medical Association at its regular weekly meeting, June 27.

"The principles of medical ethics of the American Medical Association are specifically against such practices as described in your letter as you can see from the following excerpt:

" 'It is unprofessional to receive remuneration from patents for surgical instruments or medicines; to accept rebates on prescriptions or surgical appliances, or perquisites from attendants who aid in the care of patients.'

"The Bureau of Publicity feels that it is your duty to notify your local judicial council of this situation, and the bureau suggests that the council invite the druggist in question to appear before it. It should be explained to the druggist that the proposition he made to you is unethical. It is suggested that your local council also state that the Bureau of Publicity of the Indiana State Medical Association will refrain from publishing the name of the druggist in question if your local society approves of such restraint on the part of the Bureau of Publicity. The bureau, however, suggests that the druggist should be warned that a repetition of this abuse will lead to more drastic action.

"The bureau wishes to thank you for calling this to its attention, and you may be sure that the bureau will stand behind you and the council of your local society in any reprimand it thinks should be made in this matter. If anything in this letter is not clear and if you have any further questions do not hesitate to write us. Such practices as outlined in your letter are most reprehensible and are neither in the interest of the profession nor the public, and it is the duty of the profession in your county to guard the public against such abuse."

INDIANA DIVISION OF PUBLIC HEALTH
BUREAU OF COMMUNICABLE DISEASES
Monthly Report, August, 1933

The totals of the principal communicable diseases indicated by reports from health officers, physicians, and institutions of the state show a slight decrease except for typhoid fever and influenza. All counties submitted either negative or positive reports. In view of the epidemic of sleeping sickness which is occurring in St. Louis, Mo., it is very important that any case of this disease occurring in Indiana be reported to the Division of Public Health immediately.

A summary of the diseases from the urban and rural population for the month of August is given below:

Diseases	Total	Urban	Rural
Tuberculosis	93	49	44
Chickenpox	7	5	2
Measles	30	12	18
Scarlet Fever	82	53	29
Smallpox	2	2	0
Typhoid Fever	94	39	55
Whooping Cough	102	67	35
Diphtheria	41	15	26
Influenza	108	0	108
Pneumonia	5	0	5
Mumps	3	3	0
Poliomyelitis	4	2	2
Meningitis	10	9	1

TYPHOID FEVER. The total of 94 cases of typhoid fever for the current month is almost twice the total for July. However, the total compares favorably with the report for the corresponding month of 1932, when 109 cases occurred. The cases for the current month occurred in thirty-six different counties, the greatest numbers from a single county being six from Kosciusko County, and eight from Marion County.

DIPHTHERIA. There was a very slight decrease noted in this disease as compared with the previous month. The total of forty-one cases is very encouraging, as there were one hundred and seven cases reported during August, 1932. Allen County leads with a total of eight cases.

SCARLET FEVER. Very little change was noted in the number of cases of scarlet fever reported. The total of eighty-two cases is quite low, as the estimated expectancy for the month of August is one hundred and twelve cases.

INFLUENZA. The total of one hundred and eight cases of influenza for the current month is more than twice the average for the corresponding month, over a period of the last five years. This entire number was reported from the rural areas.

Ten cases of meningococcus meningitis were reported, the entire total occurring in Marion County, one case from the rural area and the remaining nine cases from Indianapolis. One case of encephalitis lethargica occurred in Warsaw, Kosciusko County. Seven cases of malaria fever were reported in Crawford County, and one case from Jennings County. Boone County reported a case of undulant fever. Cases of paratyphoid fever were reported as follows: Crawford County, two cases; Marion County, one case; and Putnam County, one case. Vermillion and Elkhart counties each reported one case of smallpox.

THURMAN B. RICE, M. D.

CLINTON COUNTY MEDICAL SOCIETY

The Clinton County Medical Society met in regular session at the Coulter Hotel, Frankfort, Indiana, September 7, 1933, at 5:30 p. m., with Dr. John S. Ketcham, president, presiding.

Upon roll call the following members were noted as present: Drs. John S. Ketcham, C. A. Robison, H. R. Royster, B. A. Work, F. A. Beardsley, R. A. Hedgecock, F. N. Thorpe, S. B. Sims, C. A. Burroughs, T. A. Dykhuizen, J. M. Johnson, M. F. Boulden, and I. E. Carlyle.

Messrs. D. Jordan and George F. Peabody, representing the National Anti-Nostrum Society of South Whitley, Indiana, met with the society.

Minutes of the previous meeting were read and approved.

Resolutions on the life and activities of the late Dr. L. L. Harding were read and approved.

In the death of Dr. Harding the Clinton County Medical Society lost its alternate delegate to the Indiana State Medical Association. The society elected Dr. John S. Ketcham as alternate.

A letter from the Fort Wayne Medical Society was read, containing a resolution regarding the lowering of dues of the State Association from $7.00 to $5.00. Upon motion our delegate, Dr. M. F. Boulden, was instructed to vote as his best judgment should direct at the time of the meeting.

The secretary made a partial report on the set-up of the State Board of Health as outlined in the meeting of the county secretaries on July 26th.

A symposium on "The Newer Things in Medicine," by Drs. Dykhuizen, Burroughs, Hedgecock, and Work, was then presented as follows: Internal Medicine, Dr. Dykhuizen; Obstetrics, Dr. Burroughs; Therapy, Dr. Hedgecock; Pneumo-Thorax and Osteomyleitis, Dr. Work.

Messrs. Jordan and Peabody then discussed the National Anti-Nostrum Society, its purposes and aims, for the consideration of the society, and made some comparisons as to the advertising contents of the cheaper and less careful magazines that are taken into our homes and the cost of such medical care to the people of Clinton County, the State of Indiana, and the United States. They asked the financial co-operation of the society in the distribution of leaflets dealing with this program.

Upon motion the president appointed the following committee to consider this proposition and bring it up as unfinished business at our next meeting. Committee: Drs. H. R. Royster, S. B. Sims, and T. A. Dykhuizen.

IVAN E. CARLYLE, Secretary.

LAKE COUNTY MEDICAL SOCIETY

The Lake County Medical Society met in regular session at St. Margaret's Hospital, Hammond, Thursday, September 14, 1933, with President Jones presiding.

The reading of the minutes of the June meeting was passed and the business of the evening presented. A letter from the

Indiana State Board of Health, regarding co-operation of Indiana physicians, in connection with the management of their tuberculosis cases, was read and on motion the society voted such co-operation. (Dr. Rice being present, he was informally advised of this.)

Another letter from Dr. Mendenhall, chief adviser to the department of maternal welfare, was read and, on motion, turned over to the Educational Committee, with instructions to get in touch with Dr. Mendenhall.

A resolution from the Calumet Township Medical Society was presented, as follows:

"That we, the Calumet Township Medical Society, do condemn the action of the Calumet and North Township trustees, in entering into a contract for medical services for the indigent of these townships, with Drs. Geo. R. Greene and Alva A. Young, respectively, as being illegal and contrary to law."

On motion, the resolution was endorsed by the Lake County Medical Society.

A letter from the Calumet Township Medical Society, asking that they be officially recognized by the Lake County Medical Society, was presented and referred to the council.

The following resolution was presented by the officers of the Calumet Township Medical Society:

"That any member of the Lake County Medical Society entering into a contract to furnish medical services in which there is:

"a. A solicitation of patients, directly or indirectly, and under-bidding to secure a contract;

"b. Where the compensation is inadequate to assure good medical services;

"c. Where there is interference with reasonable competition in a community;

"d. Where free choice of a physician is prevented;

"e. Where the condition of his employment makes it impossible to render adequate services to the patients;

"f. Where the contract, because of any of its provisions or practical results, and contrary to sound public policy, is deemed by this society unethical; therefore, any member or members of this society holding such a contract will be held as unethical and liable to expulsion." (Reference quoted from A. M. A. Bulletin, Vol. 28, No. 6.)

Since the above amounts to a proposed change in our by-laws, the chair ruled that same should be published in the October Bulletin and come up for a vote at a later meeting.

The scientific program was then entered upon, this being "Indiana University Night." Dr. W. D. Gatch, dean of the Medical Department, discussed "Some Observations on the Etiology, Diagnosis and Treatment of Peptic Ulcer."

Dr. Bond, of the Department of Internal Medicine, discussed "Angina Pectoris."

Dr. Rice, of the Bacteriological Department, talked on "The Indiana Plan, as Adopted by the Indiana State Board of Health."

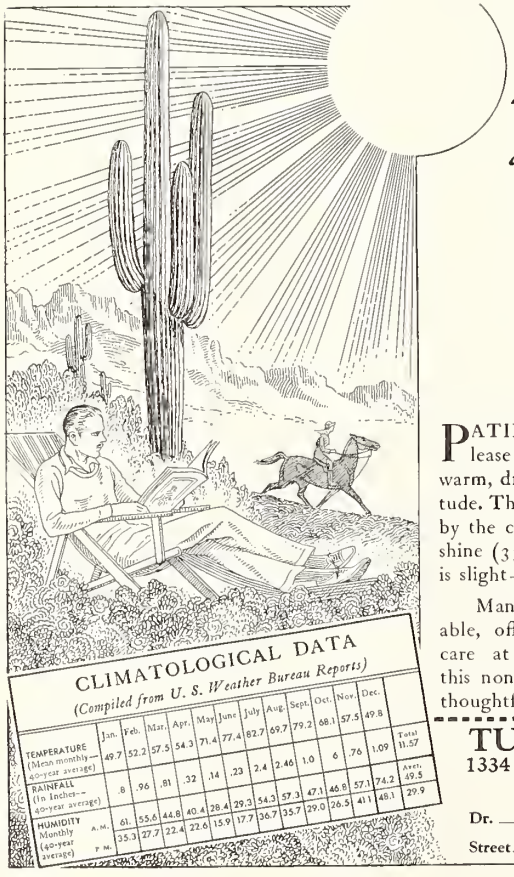
All three speakers met with a hearty reception and the discussion following each of the presentations was snappy and to the point, more than the usual number of members engaging therein. Much interest was shown in the outline of The Indiana Plan, as presented by Dr. Rice. The society voted to support the plan in toto.

President Jones thanked the speakers for their long trip to the Dune country, that they might bring to us such interesting messages.

Dr. N. K. Forster, chairman of our educational committee, won a full meed of praise for the very efficient manner in which he carried out his duties as telephone page for the evening.

Adjourned.

E. S. JONES, *President.*
E. M. SHANKLIN, *Secretary.*



CLIMATOLOGICAL DATA
(Compiled from U. S. Weather Bureau Reports)

	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	
TEMPERATURE (Mean monthly — 40-year average)	49.7	52.2	57.5	54.3	71.4	77.4	82.7	69.7	79.2	68.1	57.5	49.8	Total 11.57
RAINFALL (In Inches — 40-year average)	.8	.96	.81	.32	.14	.23	2.4	2.46	1.0	.6	.76	1.09	Aver. 49.5
HUMIDITY Monthly (40-year average) A. M.	61.	55.6	44.8	40.4	28.4	29.3	54.3	57.3	47.1	46.8	57.1	74.2	29.9
P. M.	35.3	27.7	22.4	22.6	15.9	17.7	36.7	35.7	29.0	26.5	41.1	48.1	

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VOLUME XXVI NOVEMBER, 1933 NUMBER 11

ORIGINAL ARTICLES

MEDICAL ASPECTS OF ENDOCRINE THERAPY*

THOMAS FITZ-HUGH, JR., M. D.
PHILADELPHIA

I shall attempt to give you an epitome of the uses and limitations of present day endocrine therapy from the standpoint of an internist. Even if I were qualified I could not lead you, in an hour, to the first rim of the panorama that is envisioned by many real enthusiastic endocrinologists. They see the hormone factor in almost every aspect of clinical practice, whether it be in the falling out of hair after typhoid fever, or that attack of "the blues" that follows "flu"; whether it be the maiden's menstrual cramps or the mother's "migraine"; the constitutional susceptibility to infantile paralysis and peptic ulcer or the behavior-disturbances of dementia praecox.

As Hoskins[1] has recently said of the internal secretions, "their potency is almost unbelievable. Their influence is pervasive in all that we do and are. In the present they cooperate in determining the forms of our bodies and the working of our minds. In the past they may have set the pattern of our advancement through the ages."

But to come down at once to practical applications there are only six endocrine glands (counting the gonads and their accessories as one) from which one or more hormones have been isolated that are of actual clinical value.[2]

The therapy of pituitary disorders and the uses of pituitary hormones in clinical practice are best introduced by presentation of a clinical classification.

The uses of posterior-lobe extract pituitrin (pitressin or pitocin) in general medical, surgical and obstetrical practice require no mention before this audience.

The potent hormones of the anterior lobe are of too recent extraction and too limited availability to warrant any dogmatic clinical assertion. My personal feeling is one of caution. We are undoubtedly seeing all around us, among our children as well as our adults, instances of minor grades of pituitary dwarfism and gigantism and adiposo-genitalism that at the present writing do not warrant energetic treatment with growth and sex hormones whose late and remote effects are not yet fully ascertained and whose clinical action is less convincing than the effects obtained in laboratory animals. Our experience with the use of anterior lobe sex hormone (antuitrin S, follutein and prolan) in the control of certain cases of functional uterine bleeding has been reasonably good, however, and the clinical value of Evans' growth hormone in the treatment of a midget has been attested by Shelton of California. (Hoskins, loc. cit., p. 158.)

HORMONE	PREPARATIONS	CHIEF SOURCES	ADMINISTRATION AND DOSAGE
Sex hormone Ant. lobe of pituitary	Antuitrin S. Prolan Follutein	Urine of Pregnancy	Hypodermic—q.s. (1-2 c.c. daily to weekly)
Growth hormone Ant. lobe of pituitary	Antuitrin G. Tethelin Phyone	Anterior Pituitary gland tissue	Hypodermic—q.s. (1-5 c.c. daily to weekly)
Post-lobe hormone	Pituitrin (Pitressin) (Pitocin)	Post-lobe Pituitary tissue	Hypodermic—q.s. (0.5 to 2 c.c.) and by nasal instillation
Parathyroid hormone	Parathormone	Parathyroid gland tissue	Hypodermic and intravenous—q.s. ad blood calcium (5 to 30 units)
Thyroid hormone	Thyroxin	Thyroid gland and synthetically	Oral and hypodermic and intravenous —q.s. ad basal metabolism (0.1 to 10 mgms. of thyroxin) (.05 to .5 gms. thyroid)
Pancreatic hormone	Insulin	Island tissue	Hypodermic and intravenous q.s. ad blood sugar (5 to 50 unit doses)
Adrenal medullary hormone	Adrenalin	Medullary tissue and synthetically	Hypodermic and intravenous 2 to 20 minims of 1:1000 sol. Also locally for local action
Adrenal cortical hormone	Cortin Eschatin	Cortex tissue	Hypodermic and intravenous 10 to 50 c.c. daily
Graafian follicle hormone	Theelin, estrin, folliculin, progynon, etc.	Urine of pregnancy	Hypodermic 25 to 100 "units" daily (and by mouth or suppository in 5 x dosage)
	Amniotin	Fetal fluid	
Corp. luteum hormone	Progestin	No very effective preparations available	
Placental hormones	Collips fractions 1, 2 and 3	Placental tissue	Emmenin (2) is effective by mouth as well as by hypodermic

Chart No. 1

* Delivered in Richmond, Indiana, June 1, 1933, as part of the Second Annual Postgraduate Instructional Course of the Indiana State Medical Association.

The parathyroids in clinical practice are of interest chiefly in their effect upon calcium metabolism. Overfunction or hyperparathyroidism is associated with excessive mobilization of calcium from the "store-houses," usually increased blood calcium, and often increased excretion of calcium (and phosphorus) in the urine and feces, and a resulting condition of osteoporosis, or osteomalacia, or osteitis fibrosa cystica. This condition of hyperparathyroidism should be thought of by the diagnostician confronted with any case of multiple bone rarefaction or pathological fracture. Most of the cases reported have been due to parathyroid adenomas and some have been greatly benefited by surgical extirpation and a few by parathyroid x-ray irradiation. Later if precipitated into a condition of parathyroid deficiency these patients may require replacement therapy with parathormone and calcium.

Pituitary Disorders	Their Treatment
I. Anterior Lobe Deficiency Hypopituitarism (Dwarfism) Lorain-Levi Syndrome (Cachexia) Simmond's Disease	Whole pituitary (massive if at all) Anterior Lobe growth hormones (Evans') Squibb & Lilly and P.D. Co's Antutrin G. Ant. Lobe sex hormones follutein, Ant. S., and Prolan. Sometimes thyroid extract, high caloric diet (iron, vitamines, calcium)
II. Anterior Lobe Hyperactivity Hyperpituitarism (Gigantism) (Acromegaly)	X-ray—Surgery—Later on replacement pituitary therapy in late exhaustion phase. Sometimes pituitrin.
III. Neuropituitary Dysfunction Adiposagenitalism (Frohlich's Syndrome)	Pituitrin (pitressin); Ant. lobe sex hormones; Thyroid hormone. Dietary restrictions. Gonadal hormones (?)
IV. Tumors A. Intrasellar adenoma (all ant. lobe) Acromeghalic (eosinophilic) Non-acromegalic (chromophobic and basophilic) B. Supra-Infra and Para Sellar	X-ray—Surgery—and symptomatic replacement therapy.
V. Neuropituitary Syndromes Headache, epilepsy, diabetes insipidus, etc.	Symptomatic Endocrine Replacement. Pituitrin—Ketogenic diet Elimination.

Chart No. 2



Fig. 1. Pituitary cachexia (Simmond's disease?) in patient aged 25. Never menstruated. (From the service of Dr. Alfred Stengel, Hospital of the Univ. of Penna., 1928.)

Hypoparathyroidism is associated with low blood calcium and its consequences—spasmophilia and tetany. These conditions are sometimes strikingly remediable by parathormone injections, calcium and phosphorus, viosterol, and ultraviolet ray therapy and such anti-alkalosis measures as dilute hydrochloric acid medication and ketogenic diet with high calcium content.

The chief contributing causes of hypoparathyroidism (or rather of hypocalcemia) are: First, surgical injury to or removal of parathyroids in operation for goiter; second, pregnancy; third, gastrointestinal disturbances with diarrhea and loss of calcium; fourth, insufficient calcium and insufficient vitamine D in the dietary; fifth, rickets; sixth, alkalosis; seventh, insufficient sunshine; and eighth, theoretically at least, various infections and toxemias which may depress parathyroid function.



Fig. 2. Note xanthomatous lesion of left temple. This involves the bone. Christian's disease. Xanthomatosis, exophthalmos, and diabetes insipidus, girl, aged 5. Service of Dr. Jos. Stokes, Univ. of Pa. Hosp.

Parathormone is employed in a variety of non-endocrine diseases—as for example in the attempt to correct certain types of hemorrhagic diathesis (particularly obstructive jaundice) and more recently in the treatment of atonic constipation and megalocolon. The results in our experience have not been convincing.

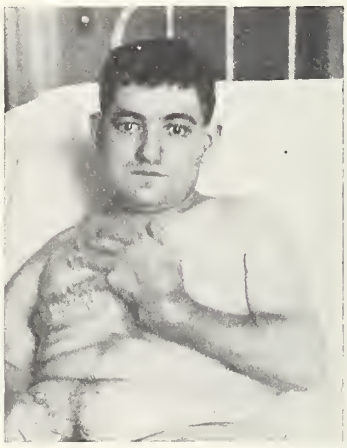


Fig. 3. Hyperparathyroidism. Service of Dr. Schnabel, Phila. Genl. Hosp. (Reported Med. Clin. of N. Am., Jan., 1931.)

The treatment of thyroid disorders and the uses of thyroid extract and thyroxin have become so regular a part of the physician's job today that little need be said.

The great advances made in the surgical treatment of toxic goiter, the preoperative and prophylactic use of iodine, and in some cases the use of roentgen-ray therapy have altogether established

a highly creditable and satisfactory *modus operandi* against the pervasive menace of toxic hyperthyroidism.

Against the reverse type of thyroid disorder—hypothyroidism with its attendant manifestations of cretinism or of myxedema—the proper administration of thyroid substance or of thyroxin is a potent and generally successful method of attack.

The not uncommon association of thyroid deficiency with gonadal and pituitary disorders makes the judicious use of thyroid hormone a frequently valuable adjunct to other forms of therapy.

Thyroid substance is also of some value in the treatment of certain cases of nephrosis and certain cases of anemia as well as in the attempt, which is sometimes successful, to cure non-toxic colloid goitre by non-surgical means.



Fig. 4. Myxedema. Patient is wearing a wig. Basal metabolism minus 35%. Moderate anemia. (Service Dr. Stengel.)

It is well to remember that dessicated thyroid and thyroxin both have a latent period of a few days between the initial administration and the development of symptomatic effects. The basal metabolism, while most important, should not be accepted as the sole guide to therapy of either hypo- or hyperthyroidism—especially when its "readings" run counter to all the other clinical indications in any given case. The margin of error in basal metabolism estimations is a rather considerable one at times and the response of different patients to comparable doses of thyroid hormone is subject to idiosyncrasy that can not always be predicted.

The incretory disorders of the pancreatic islands comprise, first, that very common malady diabetes mellitus or hypoinsulinism and second, that much less common but increasingly important condition known as hyperinsulinism (or spontaneous hypoglycemia).

The treatment of diabetes mellitus with or without insulin is too large a subject for this lecture. All we can do here is say with Joslin, "thank God for insulin." And thank Banting and Best and Collip and Macleod, and thank the nameless "caretaker" in Professor Minkowski's laboratory who made the fundamental observation that the urine of the professor's depancreatized dogs was attracting swarms of flies. And finally as Hoskins (loc. cit., p. 316) remarks "What thanks shall we render to the dogs whose graves serve as silent milestones in the long ascent of the trail? * * * perhaps but for their aid the discovery (of insulin) would still lie in the future and an aggregate of many thousands of years of human life would already have paid the price of continued ignorance."



Fig. 5. Cretin, 14 years of age; 3 feet 4½ inches tall; weight, 42 pounds. October, 1928 — before treatment. Thyroid clinic. (Service of Dr. Edward Rose, Hosp. Univ. of Penn.)

The treatment of spontaneous hypoglycemia (hyperinsulinism) is best accomplished[3] by frequent feedings of a diet of the ketogenic type—high in fat and protein and low in sugar, with most of the carbohydrate furnished in the form of 5 to 10 per cent vegetables and fruits. A few remarkable cures of hyperinsulinism have been effected by skillful surgery of the pancreas — partial pancreatectomy and removal of pancreatic neoplasm of overfunctioning island tissue.

The uses of insulin in the treatment of disturbances not associated with diabetes mellitus have increased greatly in recent years but have not proven themselves to be very important in our experience and are not without possible danger. I refer particularly to the insulin treatment of malnutrition and to the usually unnecessary addition of insulin to the more important intravenous administrations of glucose and saline solutions in nondiabetic acidosis, dehydration, starvation and shock.



Fig. 6. Cretin after three months' treatment (Feb., 1929).

The adrenal glands secrete from the medulla the hormone adrenalin and from the cortex the recently isolated hormone cortin (Hartman) or eschatin (Swingle and Pfiffner).

The number of clinical disorders that have from time to time been ascribed to the adrenal glands is too large to count. You are all familiar with that nebulous pseudoentity known as *hypoadrenia* or *adrenal asthenia*. This is the other name for that "tired feeling" which afflicts so many of our patients. Into this category have been placed many of the neurotics,

and asthenics, many of the hypotensives and visceroptotics and many of the weak brothers and sisters who go the rounds of doctors and quacks and patent medicine dispensers seeking the magic cure. We have, alas, not yet arrived at the answer, if answer there be, to this enchanting hypothesis of "hypoadrenia." Perhaps the new adrenal cortex hormone may prove to be a step toward its solution. Certain it is that there is no valid scientific evidence to support the practice, to which I thank many of us would have to plead guilty, of prescribing the ridiculously small doses of proprietary preparations of adrenal gland substance to be taken by mouth.

Diseases in which the adrenals are known to be deficient are Addison's disease, acute medullary necrosis, adrenal apoplexy, and that rare anomaly of congenital absence of adrenals which is invariably associated with anencephaly.

The treatment of Addison's disease has made a recent brilliant advance with the advent of cortin. The difficulty of obtaining adequate amounts and the high cost of this hormone will have to be overcome before it can be widely used, however.

Cortin is also recommended, together with adrenalin, in the treatment of adrenal apoplexy and acute adrenal insufficiency which sometimes



Fig. 7. Same case, after continued treatment. July, 1931. Menstruation began one month after this photograph was taken (seventeen years old). (Same case as Fig. 6.)

develops in severe infections, burns, and intoxications. It is being tried in a great variety of other conditions such as agranulocytic angina, surgical shock, etc., but no definite results are available for analysis at this writing.

In addition to the aforementioned adrenal deficiencies there are two types of adrenal hyperactivity which are both fortunately rare. One is so-called paroxysmal hypertension which results from neoplasm of the adrenal medullary tissue with consequent overproduction of adrenalin. The other is the result of cortical overactivity from hyperplasia or neoplasm (as in hypernephroma). This hypercortinism produces (with pituitary and gonadal collaboration) the various pictures of congenital female pseudohermaphroditism, adolescent *pubertas praecox*, and adult *adrenal virilism*.

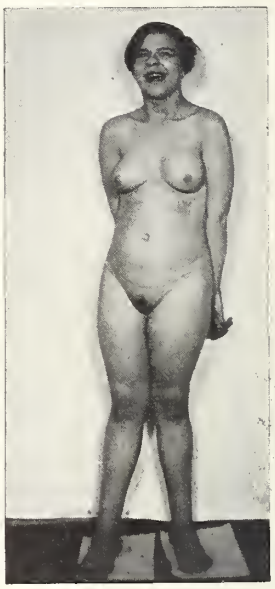


Fig. 8. Same patient, February, 1933. After a little more than four years of treatment, patient is 5 feet, 1 inch tall; weighs 112 pounds; normal menses; active, happy disposition, but mentally retarded at about 10-year level. (Same case as Fig. 6 and 7.)

Very few of the endocrine gonadal disturbances are amenable to cure by endocrine therapy, in spite of the brilliant advances made during the past few years.

The two ovarian hormones, one from the Graafian follicle (theelin, theelol, folliculin, estrin, amniotin, progynon) and the other from the corpus luteum (progestin) are of great physiologic interest and of some diagnostic importance but are thus far of little proven value as therapeutic agents. The first, or follicular hormone, is obtained commercially from the urine and amniotic fluid of pregnant animals and women. These together with the sex hormone of the anterior pituitary (also present in excess in the pregnant maternal organism and her urine) constitute the physiologic bases for the various tests: the diagnosis of pregnancy, the diagnosis of fetal death and inevitable abortion, the diagnosis of the cause of the several types of amenorrhea, the diagnosis of hydatidiform mole and chorion epithelioma, and in some instances of testicular neoplasm and teratoma.

In the treatment of functional amenorrhea and oligomenorrhea the use of theelin (folliculin or estrin, amniotin or progynon) may produce periodic uterine bleeding but it is questionable whether this is true menstruation. This follicular hormone is

also used in the treatment of menopausal symptoms, with variable results somewhat suggestive of those attributable to psychotherapy but in general fairly satisfactory. In the obese cases of amenorrhea, thyroid hormone in small doses is a valuable adjunct. Theelin is of some apparent value in the treatment of functional sterility with or without the adjuvant effect of anterior pituitary sex hormone.

Small so-called stimulative doses of x-ray applied to the ovaries and pituitary are also recommended for functional amenorrhea and sterility but personal experience has not been very convincing.

For functional uterine bleeding the use of anterior pituitary sex hormone (with or without thyroid medication) has been very satisfactory in a majority of our cases. For the menopausal type

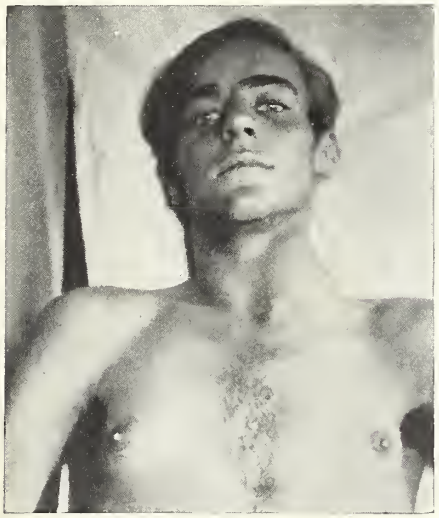


Fig. 9. At 18 years of age developed testicular tumor and metastases, marked gynecomastia and strongly positive Friedman test. Necropsy showed chorioma testis with metastases.

of hemorrhage it is worse than useless. The rest of the treatment (in case hormone therapy fails) consists in curettage, x-ray and radium irradiation or hysterectomy.

For the distressing manifestations of functional dysmenorrhea—with cramps, nervous tensions, headache, nausea and prostration—there is as yet no panacea. Some of these young women seem to exhibit over-formation and retention of the sex hormones (Frank's hormone tension hypothesis) and are sometimes benefited by measures designed to promote hormone elimination and excretion—such as saline purgation or biliary drainage prior to menstruation. Others exhibit evidence of hormonal insufficiency and are occasionally benefited by substitution therapy.

One other practical aspect of gonadal endocrinology should be mentioned: the question of the period of maximal fertility and infertility in relation to the menstrual cycle. The evidence is clear that the period of maximum infertility during which marital relations are least likely to result in pregnancy is the last week preceding menstruation. During this time the ovum, which was presumably discharged from the ovary at the mid-period about fourteen days after the preceding menstruation, will have been destroyed or excreted and the spermatazoa will not retain their vitality long enough to survive the succeeding menstruation and the twelve to fourteen day wait necessary for the next ovulation. Conversely the period of greatest fertility is the mid week between menses.

Before leaving the topic of ovarian therapy mention should be made of Birch's theory and treatment of hemophilia—as a disease caused by lack of the supposed normal female sex hormone moiety of the hemophiliac male and remediable by massive ovarian gland administration. Our own results have not been convincing. One wonders why the old fashioned whole-ovary preparations should be more effective than the newer hormones? It is also interesting to speculate on what might happen to the mothers (of hemophiliac sons) who might undergo bilateral oöphorectomy and why some of these mothers do not themselves exhibit active hemophilia after the menopause.

For masculin gonadal disturbances there is even less of established therapeutic value. Deficiency of incretory function, resulting from castration, infection, destructive neoplasm, senility, fibrosis, or primary aplasia produces the various gradations of eunuchism.

The testicular hormone of the interstitial cells has been secured in fairly purified form but only in such minute quantity that its clinical use is not yet practicable. The various attempts at replacement therapy by injections of fresh testicular substance, gland transplants, and the so-called rejuvenation operations of Steinach are not yet accepted by conservative students as indicating much more than temporary triumphs of psychotherapy.

Time forbids discussion of other organs exhibiting certain endocrine functions, such as the pineal, the thymus, the prostate, the liver, stomach and intestines and of other hormones such as secretin, cholecystokynin, Addisin and perhaps the active principles of liver extract and ventriculin.

We cannot in this brief survey devote time to discussion of the work, results, and interesting hypotheses of Cannon and others. There are here implied the suggestions that many body cells are "factories" for the elaboration of specific hormones and that much of the physiologic activity heretofore ascribed to direct nerve stimulation is mediated by such hormone generation and action.

We shall close with a philosophic and perhaps hopefully agnostic reflection concerning endocrine therapy in general.

The only proven hormone agents of clinical value that may be effectively administered by mouth are, first, thyroid hormone; second, emmenin from the placenta; and, third, to a slight extent, the follicular hormone of the ovary. All the rest must be given by hypodermic injection—with the possible

exception of the intranasal use of pituitrin and the suppository method of administering follicular hormone. The necessity of parenteral administration is a serious handicap in the general practice of proper endocrine therapy and is a reason, but not an acceptable excuse, for the widespread employment of innumerable proprietary "gland products" that are for the most part totally inadequate as to dosage, probably useless, and certainly expensive. If the practitioner wishes really to make the clinical experiment of oral glandular therapy with products which the world's scientific laboratories have pronounced to be without detectable activity when so administered, he should then "go overboard" completely in favor of massive dosage. This is the constantly recurring theme and emphasis of a few sound clinicians whose experience and belief in the efficacy of orally administered massive doses of certain glandular substances must command our attention, notwithstanding negative "scientific" evidence to the contrary.

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INDIANA'S INDIGENT RELIEF PLAN*

By WILLIAM H. BOOK

Director of the Governor's Commission on Unemployment Relief

INDIANAPOLIS

I told Dr. Padgett that I would attempt to summarize the points I tried to make during the luncheon program, but I think after all you would get the information you want more easily if questions were asked, which might cover some points I failed to cover. There are many details about the operation and many questions arising which only experience can answer. But we are learning from the different situations which come up and will try to profit by experience and the mistakes we make from time to time.

The basis of all that we are trying to do in regard to medical aid is that necessary medical aid will be given by the public relief agencies. The Federal Emergency Relief Administration has said that the conservation and maintenance of public health is the primary function of our government, and we recognize that conservation of public health is the primary obligation of our relief administration. We are going to see, at least in the counties in which we operate, that medical aid is given according to its needs. In the second place, we will deal with the organized medical associations. We have felt from the beginning that that was the feasible way, and we are pleased to find Washington saying that we should undertake our arrangements with the state and local medical associations. It has been something like two months since we began conversation on this subject with the Executive Committee of the State Medical Association, and we were never far apart. We are now in pretty general agreement on the fundamental program to be carried out, to be placed in the hands of our county chairmen, and we expect the outline of the program to be followed. That is not a specific contract, but simply the fundamental principle on which contracts may be arranged. In other words, we are asking local relief organizations to meet with the medical societies and use this outline as a basis, but work out their own arrangements. It does not need to be a written contract, but will be the arrangement which we will follow in interpreting the situation from month to month as changes are needed. We have tried to impress this understanding—that medical aid to be given to the indigent must have some control, but in any emergency medical aid is to be given by the relief organization. We think an emergency requiring medical aid should be where an indigent person is suffering from an acute medical or surgical condition requiring treatment for the elimination of pain or the restoration of normal activities, or any chronic condition requiring treatment for preservation of life. We are depending on the good judgment of our staff members and the physicians to solve these problems, and to work out the individual case at the particular time. We are having reports of the using of poor relief funds to pay for hernia operations, the trouble being of long standing and no emergency indicated. There have been reports also of tonsillectomies and treatments for neurotics paid for out of the poor relief funds. We are simply trying to say that with the exercise of good judgment we will give medical aid at the public expense to those who, being indigent, are suffering from an acute medical or surgical condition and need treatment for the elimination of pain, the restoration of normal activities and the preservation of life. We find the federal administration has followed about the same general idea as to the kind of aid that may be paid for.

In determining the amount that will be paid we wish it understood that there is a very definite limit to the funds available for this problem, and every locality is limited in the funds which it can obtain. It will not be possible to provide adequate poor relief in this state and continue to pay the doctors as they have been accustomed to be paid. The Executive Committee of the medical association pointed out to us certain facts with regard to the economic situation of physicians, and we proposed that physicians giving medical aid to the indigent shall receive not to exceed 50 per cent of the customary fees for this service, realizing that in so doing the physician would be contributing to the welfare of his community.

We have not stipulated a schedule of prices for

* Presented at the French Lick session of the Indiana State Medical Association, September, 1933.

surgical operations, x-rays, etc., although we are ready at any time to advise our local organizations what we regard as reasonable fees for that service, and we feel confident, after our experience with the Executive Committee of the medical association, that we will always be able to find a basis of adjustment.

We would like to establish this point, that the issuing of an order for medical aid rests entirely with the investigator. After all, the investigator is the only one who can judge the needs of the particular person or family. Of course we recognize that the physicians on their rounds will find situations where emergency medical relief is required that do not come to the knowledge of the investigator, and we have instructed the investigators that where a physician gives his services, as he naturally would do, we will make an equitable adjustment. In other words, while we depend upon the investigator we are ready at any time to meet an emergency situation, and there need be no question about giving the necessary service. We are trying in this whole business to say that necessary red tape comes second, and giving medical aid first. We will give the aid and then find a way of working out the red tape problem.

There are only 38 counties that have qualified for federal aid. I am not sure that some of those counties will continue to receive this aid, as they give evidence of some resources for meeting their own needs. In the federal aid counties we hope with the exercise of due discretion in bringing about the federal plan that a satisfactory medical program will be carried out. In the non-federal aid counties the situation is not quite the same. We are not placing any money in those counties. We can only act in an advisory capacity. Our plan will be placed in the hands of our county chairmen, in both federal aid and non-federal aid counties. In the first group we feel sure that in only a short while this relief program will be working satisfactorily. In the others we feel confident that, given some time, our county chairmen will be able to bring about a satisfactory program suited to their needs. We are pleased that in two communities in the state two contracts have been arranged on the basis of the program I have presented. In the first the county officers thought they could make a better bargain, but we are not out for bargains, but for giving the necessary medical aid. That county has completed its contract now and it will be placed in operation October first. The county medical society, on its own initiative, proposed that the billing of the township for medical aid in September should be on the same basis as in the contract which will go into effect October first. We think that was a very magnanimous act on the part of the county medical society. In the other community the contract has been arranged for payment on a different basis. Here we proposed that the medical society and the relief administration agree on what seemed to be a fair monthly amount to be distributed pro rata to the physicians, according to the service they have given.

There is some routine to be followed out in connection with this service. We have an order form which we use for all relief given, whether food, shelter or medical aid. This is a uniform record requiring the signature of the relief official and the investigator. At the conclusion of the month this order form should be filed in the relief office by the physician when he files his bill for services rendered. That bill will show the necessary detail which I think you will recognize must appear. The itemized bill with the original orders for services when filed with the relief agency is to be audited and transmitted to the department which will eventually pay the bill.

Probably there are some questions you would like to ask. We are pioneering in what we are trying to do. We would not have gone as far as we have if it had not been for the Executive Committee of the State Medical Association. We will try to profit by our mistakes. We ask from the members of the organization that as you see mistakes made in the field you will report them to our office. We may not always agree that mistakes have been made, but we will try to bring our views together, and we hope you will understand that we are trying to be sincere in meeting these problems.

Dr. F. S. Crockett, Tippecanoe County: Is it true that money paid out for medical poor relief is a loan to the county that must be repaid?

W. H. Book: No, sir. The federal aid which is given the county is a direct grant, not to be repaid. I think this ought to be understood, however, that the amount of federal aid available to this state will not be enough to do more than pay about 50 per cent of the entire relief bill for the counties now asking for aid for the remainder of this year. Beyond that time we cannot see very far. We have anticipated that the federal government will probably continue its present plan of making the counties furnish one dollar for three for relief in Indiana. That means that we can carry about one-half the load. That means that when it comes to paying the bill for Tippecanoe or any other county federal aid will be available in cash at the end of the month, but the county and townships must be looked to for the money to pay the rest. I believe the Supreme Court has recently opened the door for the local financing of relief. That has been closed since the enactment of the tax limitation law last summer. Townships now clearly may issue bonds which will be used for financing relief. Most townships facing this problem have a very small amount of indebtedness and therefore ought to be able to sell their bonds. If difficulty arises every possible step will be taken by the state to help the township to float its bonds. My opinion is that federal aid will be available to pay about one-half of these bills. There will necessarily be some delay. The procedure for issuing township bonds will probably

take forty-five to sixty days after the close of the month.

DR. S. P. HOFFMAN, Allen County: In a county where the trustee and the medical men take care of the county relief, and if the medical society in that county is perfectly willing to take care of the relief, just how far does the state want backing by the local society in the distribution of the communities?

W. H. BOOK: I suppose that is Allen County, because we have had a rather knotty problem up there. In some counties where a group or a single physician has been rendering medical relief on contract there is evidence that medical aid is being given inadequately and at excessive cost. In Allen County, I think, there is no reason to believe that medical aid is being given unsatisfactorily, and I am quite sure there is not any difference of opinion that medical aid is being given without excessive cost. We realize that the township contract there involves only a few physicians, but it seems that service is being given satisfactorily and without excessive cost. In such a situation it seems to me it is necessary for the medical profession in that community to get together to work out the problem.

DR. S. P. HOFFMAN: I am not satisfied with the answer. The society is perfectly willing, but they want to know how far the state representatives in that community will back up the society.

W. H. BOOK: So long as the medical aid is being given satisfactorily; so long as the service is adequate for that community we are not going to make any change in that arrangement.

DR. S. P. HOFFMAN: According to the pamphlet they are sending out Allen County has no chance to participate.

W. H. BOOK: No, sir, the medical profession in Allen County can work out your problem. We are willing to back up your society, but as long as there are two factions in your medical society we are not willing to act as umpire in the conflict.

DR. B. O. BURRESS, Daviess County: Is someone in each county designated to handle and distribute this federal aid in the county?

W. H. BOOK: In perhaps one-half of the counties we have a staff at work. For the remainder we have not yet been able to find enough trained people. In Daviess County we have not appointed a staff member, but in the meantime in those counties there is a county chairman, not on a salary, who is giving his time and is able I am sure to help work out the problems.

DR. B. O. BURRESS: The question is the distribution of money.

W. H. BOOK: In Daviess County the claims go direct to the auditor and claims are paid by him when presented and approved by us.

DR. B. O. BURRESS: The trustee passing on all the orders and saying whether the bill is O. K.?

W. H. BOOK: We expect to establish in all of these counties a staff member who will assume authority for all relief investigation and distribution. That person will be a social worker, trained in relief work.

DR. S. P. HOFFMAN: How do you determine whether medical aid is adequate or not?

W. H. BOOK: Of course there is no definite way now. We take the testimony of relief officers and members of the profession. You understand that in Allen County there is no claim that the service is unsatisfactory. The majority of members of the society seem to feel, however, that they are being compelled to give too much service to indigent persons for which they are not paid. I have asked twice for testimony on that subject and none has yet been received.

DR. S. P. HOFFMAN: From whom does the testimony come—from the medical society?

W. H. BOOK: Those we assumed were responsible members of the society are the only ones we have asked. Anyone who has information should be willing to give it.

DR. J. H. WEINSTEIN, Vigo County: The federal plan states that the indigent should be given the right to choose the physician, but your plan in Allen County does not do that.

W. H. BOOK: That is true. However, the plan which is started in Indiana and the situation in Allen County have been discussed with field representatives of the federal emergency relief administration, and thus far we have not been advised to make a change. In general we are going to try to make arrangements with the trustee and the medical society that will give the indigent family the services of their customary physician. There is an exception in Allen County. I imagine that exception will be worked out, but somebody else will have to share the burden of doing so.

DR. W. A. THOMPSON, Union County: We have the situation of two counties forming a medical society—Wayne and Union. Will the ruling you make in Wayne County apply to Union County?

W. H. BOOK: I do not think that necessarily follows. It may be the physicians in Union do not wish it that way—it will have to be worked out each county for itself.

DR. W. A. THOMPSON: There will be two separate persons in charge?

W. H. BOOK: We have a chairman in Union County, but we are not giving federal aid there. We have a chairman in Wayne.

DR. W. A. THOMPSON: I am a member of the Wayne County society, but live in Union County. If I make an agreement with you would that apply in Union County?

W. H. Book: The agreement in Union County must be made with the local relief officials. Our chairman should be asked to participate.

Dr. H. D. Caylor, Wells County: What counties are qualified for federal aid?

W. H. Book: Lake, Porter, Laporte, St. Joseph, Elkhart, Allen, Tippecanoe, Howard, Huntington, Blackford, Grant, Marion, Delaware, Wayne, Madison, Vigo, Vermillion, Clay, Parke, Sullivan, Greene, Monroe, Hendricks, Johnson, Bartholomew, Shelby, Martin, Orange, Jackson, Jennings, Knox, Daviess, Gibson, Pike, Warrick, Vanderburgh, Clark and Floyd. (Since the time of this discussion, two others have been added, Clinton and Morgan.)

Dr. J. R. Crowder, Sullivan County: Is your committee going to furnish aid in the treatment of venereal diseases?

W. H. Book: We are not going to pay the cost of any clinics. Does that answer the question?

Dr. J. R. Crowder: No. Any individual—not a clinic proposition—those indigent people who are suffering from venereal disease?

W. H. Book: Is clinic aid available?

Dr. J. R. Crowder: It is not.

W. H. Book: I am afraid we will have to pay for it.

Dr. J. R. Crowder: Who is to pay for it? Does it go back to the trustee?

W. H. Book: Yes. (Note—This answer is not correct. This problem is one of the State Board of Health—W. H. B.)

Dr. J. R. Crowder: Your committee will not furnish any aid to the trustee to meet this expense?

W. H. Book: Yes, we will, but that will be handled through the county organization.

Dr. J. R. Crowder: So far that proposition has not been brought up in our country. We have your representative in our county, but so far the treatment of venereal disease has been laid aside.

W. H. Book: Was that service formerly given by the clinic at Terre Haute?

Dr. J. R. Crowder: Yes.

W. H. Book: Why is it not being given now?

Dr. J. R. Crowder: That clinic has been disbanded and Vigo is assuming the responsibility for the clinic and is not receiving state aid, so they will not accept patients outside of Vigo County.

W. H. Book: That is just. This is offhand judgment, but it looks as if you would have to pay the bill. I should have explained that federal aid cannot be used to pay any part of the hospital fee. Federal aid may be used to pay for nursing, for dental care and medical care, to provide drugs but the regulations specifically state that it cannot be used to provide expensive drugs and that no patent medicines are to be bought by medical aid money. But hospital fees may be provided out of county funds for relief expense.

Dr. F. S. Crockett: Does that include x-ray?

W. H. Book: If it is included in the hospital fee it does.

Dr. E. O. Harrold, Grant County: In a county where there is a fee schedule not far different from this, will the new fees obtain or those already in operation?

W. H. Book: Perhaps the emergency will be overcome by the time we get to that county. There are many other places where no arrangements can be made, and we will be several months getting to it.

Dr. E. O. Harrold, Grant County: Will the fee schedule be uniform throughout the state?

W. H. Book: No, but in general we say the fee should be no more than 50 per cent of the fees in the particular locality.

I am very grateful to this organization for the chance to say these few words, and very grateful to Tom Hendricks and the Executive Committee for their patience in working with me in trying to arrange our program in the best way. I feel certain that we are going to give a better type of medical aid to the indigent, and that the person who needs the services of a physician and gets it will be more ably treated in Indiana this winter than ever before.

LOCAL ANAESTHESIA IN LABOR

H. D. Tripp, M. D.
Kewanna

The practice of obstetrics in the home is usually more or less fraught with adverse circumstances. Among the problems confronting the physician is that of anaesthesia. Particularly is this a problem when experienced help is not available. Many cases of obstetrics have had for anaesthetists persons who have never before seen an anaesthetic administered. The husband, the neighbor, or mother of the patient are often called to perform a duty which in a well regulated hospital would not be entrusted to anyone less than a graduate nurse.

Few patients are able to be cared for in a hospital where every convenience is available; however, there are conditions which arise in the average obstetrical case in which a general anaesthetic is not necessary, but some form of analgesia, at least, is necessary if one desires to prevent severe lacerations, or if those which do occur are to be repaired. Lacerations are preventable in the majority of cases if episiotomy is done, and I venture to say that if a more practical method of anaesthesia were available, more necessary episiotomies

would be done and repaired, thus reducing the number of ultimate bad tears.

The chief objections to a general anaesthetic in obstetrics are: First, it is time consuming; second, it requires the services of a second party; third, your patient becomes unconscious about the time when her cooperation is needed most; fourth, there are the usual contra-indications to the use of a general anaesthetic.

Professor Boehler, in his fracture clinic of Vienna, several years ago introduced the use of local anaesthesia for the reduction of fractures. Further developments of this method included the infiltration of adjacent muscles, thus producing relaxation and ease in manipulation of the fragments. Being caught short on an obstetrical case without any form of general anaesthetic, and the possibility of a deep laceration occurring if episiotomy was not done, somehow brought to mind this method of Boehler's. Fortunately there was a vial of sterile novocaine with me, and I decided to use this to infiltrate the perineum in order that I might do the episiotomy and prevent the dreaded laceration. By the use of a hypodermic syringe I was able to infiltrate an area large enough to do the episiotomy and the repair. The results were so gratifying that I decided to use the method again, and now it is used routinely, with some modification, and in the twenty-five cases that I have used it I have not seen a single bad effect in either the mother or the child.

Novocaine infiltration of the perineum relaxes the muscles and eliminates that period of anguish when the child's head passes through the vulva. Every case is infiltrated for that one reason alone, even if episiotomy is not necessary. I believe that rigid muscles tear more readily than relaxed ones. Uterine contraction pains of course are not affected by the infiltration. Sodium amytal, amytal, or amytal compound greatly reduce the amount of pain from contractions, and I have recently used amytal compound with very satisfying results.

Amytal compound, composed of amidopyrine and amytal, supplies, first, an analgesic of unsurpassed value with the exception of the opiates. Second, amytal is a barbituric acid derivative and supplies a sedative and hypnotic of accepted value. Also it is known that the barbituric acid derivatives counteract the ill effects that sometimes accompany the use of novocaine. Dodek[1] showed in his work that sodium amytal does not depress the force of uterine contractions, and I have found that amytal compound likewise does not.

Usually when a general anaesthetic is administered it is delayed until the head reaches the vulva. Previous to this nothing is done to relieve the pains except to tell the patient that she must labor and bear the pain, and by the time that her cooperation is needed most she is fairly worn out. Puerperal infections have been shown to be more common in long hard labors than in the shorter and easier ones.[2] Possibly shock has much to do with the more frequent occurrence of infections in these long labors. We try to prevent as much shock as possible in surgery. Why not prevent it in obstetrics?

The technique employed is as follows: A five per cent solution of mercurochrome is used to prepare the patient after first scrubbing with a weak lysol solution. The vagina is also irrigated with the same strength of mercurochrome. In the stage of labor when the contractions are becoming painful one capsule of amytal compound is given by mouth, and is repeated in one hour if the pains are still very severe.

When the child's head begins to make pressure on the perineum about twenty cubic centimeters of 1% novocaine is injected into the perineum. The first injection is made into the perineal body and aboue five cubic centimeters are used, the needle being long enough to go past the skin and fat so that the solution is placed in the muscles. From this point the bulbo-cavernosus muscles are injected, care being taken not to injure Bartholin's glands and adjacent veins. A few cubic centimeters are also injected posteriorly to either side of the perineal body in order to catch the fibers of the superficial transverse perineum and levator ani muscles. If episiotomy is to be done then the skin of the corresponding area is infiltrated.

With the above technique I have been able to conduct labor practically painlessly, and with the cooperation of a quiet and calm patient, which certainly is not possible if all relief of pain is expected to be accomplished by the use of a general anaesthetic. I do not advocate this technique for all operative procedures in obstetrics. The method has limitations. However, for forceps delivery after infiltration of the perineum I have found that less ether is needed than when the infiltration is omitted. This is in accordance with Crile's theory of anoci-association.

Conclusions

1. A method of analgesia is described for use in obstetrics.

2. The method apparently seems simpler for the general practitioner's use than general anaesthesia.

3. Labor is practically painless conducted by this method of analgesia.

4. Labor is apparently of a shorter duration since the patient cooperates better when the fear of pain is reduced.

(Editor's Note: This paper was submitted for publication in June, 1933.)

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ATYPICAL MASTOIDITIS COMPLICATED WITH HEMATURIA

A. H. Hansen, M. D.
Hammond

Probably no one recognized lesion of the body presents wider variations in its course than does acute mastoiditis. The case described in this paper is presented as an interesting variation from the usual type.

The patient, a child six years of age, was first taken ill on November 5, 1932, with a very mild scarlatiniform rash over the abdomen and arms. There were some cases of scarlet fever in the neighborhood, and at the time the patient was thought to have scarlet fever, even though there was absence of a strawberry tongue, vomiting, and sore throat. The rash had disappeared by the second day. The patient was sent to me on November twenty-third for an ear examination, with the history that for one week previously the child had been complaining of pain in the left ear at irregular times during which the temperature would rise to 103 or 104 degrees. This patient gave a history of previously having had rather high temperatures with slight infections. Urine examination showed a moderate amount of albumen with some pus cells. Examination of the left ear revealed a drum slightly retracted but otherwise apparently normal. There was no tenderness over the mastoid, even with deep pressure. The ear canal revealed no posterior bulging. The patient was advised that the earache should be treated medically, and that the ear drum and mastoid should be carefully watched.

The patient was next seen on December first. The child had been admitted to the hospital on November twenty-seventh, because of development of hematuria on the previous day. Hospital findings up to December first were as follows:

November twenty-seventh, temperature 98.2 to 98.6, urine reddish-brown in color with a few coarse granular casts and no leucocytes, W. B. C. 12,000, R. B. C. 4,000,000, hemoglobin 50%. On this date, examination of the ear drum still revealed no findings of inflammation and no tenderness over the mastoid. On November twenty-eighth the temperature varied between 97.6 and 98.6, the urine was red, and the blood picture remained practically the same. On November twenty-ninth slight tenderness was noted on mastoid pressure, and on this day the temperature varied between 98 and 102. The temperature was 102 at 6 a. m., at which time a profuse purulent discharge began to flow from the left ear and there was increased tenderness over the mastoid. On November twenty-ninth temperature reached 103.8 at eleven p. m., and on November thirtieth temperature reached a high of 103 at 6 a. m. On December first I was again called. The child appeared very sick and anemic, and there was present a profuse purulent discharge from the left ear, and considerable tenderness of the mastoid process, particularly over the antrum. Urine examination revealed a dark red urine with few granular casts, numerous erythrocytes and a very few leucocytes. Temperature at this time (noon) was 103.6. No chills had at any time been present. Smear from the ear discharge showed gram-positive cocci, both groups and chains. An x-ray of the left mastoid revealed evidence of broken-down cells with complete loss of aeration. Blood picture showed W. B. C. 13,000 with polys; neutrophiles 80%; small lymphocytes 13%; large lymphocytes 6%, R. B. C. 3,700,000; and Hb. 45%. Patient was given a transfusion of 250 c.c. of blood by the direct method after the usual typing, and a simple mastoid operation was done immediately afterwards. The operation revealed a well developed pneumatized type of mastoid which had almost completely broken down. The dura of the sigmoid sinus, and posteriorly over the cerebellum, was considerably thickened. The bony posterior canal wall was almost broken down.

Following the operation a gradual recovery occurred. Temperature remained normal after the fourth day. A second blood transfusion of 200 c.c. was given on December third. The urine continued to be dark red in color for four days, but on December sixth became normal in appearance and remained so. On December second W. B. C. was 18,750; R. B. C. 4,200,000; and Hb. 65%. On December fifth following the second transfusion W. B. C. was 6,800; R. B. C. 4,740,000; and Hb. 80-85%.

A Dick test on January tenth was positive for previous scarlet fever.

This case was presented because of the late appearance of the discharging ear and the complicating scarlet fever.

Upon first examination, the complete absence of any physical findings of any acute inflammation in the left ear made diagnosis of acute mastoiditis impossible. An x-ray at this time might have shown a cloudy mastoid, but almost no evidence of bone destruction. The urine findings complicated the picture and suggested a possible renal cause of the fever. Two weeks intervened between the onset of the earache and the ear discharge. On November twenty-ninth, the mastoid findings would have indicated the need of a mastoid operation. From the appearance of the mastoid and the fibrous thickening of the dura, no other conclusion can be reached except that the mastoid infection had been present from and perhaps prior to the onset of pain.

The development of hematuria on November twenty-seventh was also interesting and again somewhat clouded the ear picture by perhaps being a renal complication of a mild scarlet fever present earlier in the month. The prompt subsidence of this condition following the mastoidectomy suggests that the glomerular damage was secondary to the mastoid infection. Mastoid complications are usually those associated with the dura and

brain. The case presented illustrates that mastoid infection may involve more remote tissues.

While it is practically impossible to make a positive diagnosis of primary mastoiditis, the case presented above may be considered as a possible one. Primary mastoiditis may be caused by infection from the blood stream. Bacteria from the nasopharynx passing up the eustachian tube would also have to pass through the tympanum without infecting it and lodge in some portion of the mastoid in order to produce a primary mastoiditis. The impossibility in any case of denying a previous tympanic disease makes any diagnosis of primary mastoiditis doubtful. In very rare cases, trauma may cause a primary infection in the mastoid.

THE DIAGNOSIS OF HYPERTHYROIDISM*

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H. S. Plummer's nomenclature of diseases of the thyroid gland includes the following classification of goiter: (1) diffuse colloid goiter; (2) adenomatous goiter without hyperthyroidism; (3) adenomatous goiter with hyperthyroidism; and (4) exophthalmic goiter.

Diffuse colloid goiter and adenomatous goiter without hyperthyroidism do not give rise to symptoms other than those which may result from compression of contiguous structures by the goiter. Symptoms of hyperthyroidism characterize adenomatous goiter with hyperthyroidism and exophthalmic goiter.

It is assumed that adenomatous goiter with hyperthyroidism is the result of pure hyperthyroidism; that is, excessive secretion of the normal product of the thyroid gland. The onset of the disease is insidious and the course is progressive. Hyperthyroidism seldom afflicts patients who are less than thirty years of age, although it may be initiated at any time following adolescence. After the age of thirty years, however, the incidence of hyperthyroidism increases with each succeeding decade. Seventy-eight per cent of the patients with hyperthyroidism observed at the Mayo Clinic have been forty years of age or more. The thyroid gland is enlarged and nodular. The symptoms of the disease are similar to those experienced by the normal person who has been subjected to unusual emotional or physical strain, or to the symptoms which develop following the administration of desiccated thyroid gland, with consequent elevation of the basal metabolic rate. Early in the course of the disease the hyperthyroidism may have a tonic effect on the patient's condition, producing a feeling of unusual well-being. The disease may culminate in myocardial failure, when the hyperthyroidism may be easily overlooked and the case treated as one of primary disease of the heart.

The syndrome of exophthalmic goiter may be explained readily on the basis of the two-product hypothesis; that is, production of an excessive amount of thyroxin, and in addition elaboration of an abnormal agent by the thyroid gland. The onset of symptoms of exophthalmic goiter may be sudden or insidious and the course of the disease may be chronic and progressive, or, more frequently, intermittent, with periods of exacerbation and remission of symptoms. Cure may be spontaneous. Postoperative recurrence of tumefaction and of symptoms is frequent. Exophthalmic goiter may occur at any age, even in infancy. In a series of cases of exophthalmic goiter observed at the Mayo Clinic, 60 per cent of the patients were less than forty years of age. In addition to the symptoms that occur in cases of adenomatous goiter the patient who has exophthalmic goiter manifests certain other symptoms and signs characteristic of exophthalmic goiter; namely, a peculiar nervous reaction, ocular signs, and a tendency to the development of crisis. The patient presents an appearance of tension which is characteristic of the disease, and frequently performs many useless and semi-purposeful movements. Usually the patient is optimistic and self-confident. Emotional disturbances are of frequent occurrence and during a severe phase of the disease there may be psychic disturbances, especially depression or mild, confusional delirium. The thyroid gland may or may not be appreciably enlarged. Characteristically the thyroid gland in exophthalmic goiter is enlarged diffusely and symmetrically. In approximately 80 per cent of untreated patients localized bruits and thrills over the poles of the thyroid gland may be detected; these are considered diagnostic of exophthalmic goiter.

The recognition of hyperthyroidism early in its course is important inasmuch as surgical procedure at that time is associated with less risk, and is followed by more satisfactory results than later in the course of the disease. Early in the course of hyperthyroidism it may not be possible to distinguish definitely between exophthalmic goiter and hyperfunctioning adenomatous goiter, but this is not so essential as recognition of the hyperthyroidism since both diseases usually are treated surgically.

* Abstract of paper given before the Indiana University Seminar, Indianapolis, March 25, 1932.

AN INDIANA MEDICAL LIBRARY

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INDIANAPOLIS

Until very recent years Indiana had no library that adequately filled the needs of the research worker in the medical field. In the adjoining states of Illinois, Michigan, and Ohio there were a number of excellent medical libraries; states somewhat further removed also were well equipped,

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while the extreme eastern states possessed some of the largest and most complete medical libraries in the world. The local need for a library that could meet the wants of the practitioner and of the man engaged in medical investigation had long been felt, and it was only the lack of necessary funds that prevented its establishment.

In recognition of this need the legislature of the State of Indiana, in 1927, made a special appropriation in two annual installments for the creation of a library to be founded under the auspices of the Indiana University School of Medicine at Indianapolis. Following these two yearly grants a generous appropriation for the two succeeding years from the general funds of the Indiana University School of Medicine enabled the new library to carry on the work of development which already was well begun. Later appropriations have necessarily been much decreased; nevertheless, the library has continued to grow until it now meets the needs of the profession in a very fair degree. It is the hope that in the near future further appropriations and a lessening of the costs of a number of exorbitantly priced but very important foreign publications will enable us to supply our greatest remaining needs.

The library was fortunate, during the time of its greatest expansion, in having at the head of its library committee Dr. Bernard B. Turner, whose knowledge of science in all its branches and whose wide acquaintance with the scientific and medical literature of all nations was invaluable during the library's formative period. Without the aid of one so qualified and willing to devote the many months necessary not only to determine the greatest and most pressing scientific requirements, but also to decide the many questions arising in connection with the offers of medical book dealers, the founding of a satisfactory medical library would have been a matter of most uncertain result. It was through Dr. Turner's aid that we now have a well balanced medical library.

Although the library first began its real growth following the above mentioned direct legislative appropriation, it may be said to have had its inception in the library established by the bequest, in 1870, of Dr. John Stough Bobbs, the "founder of cholecystectomy," whose will left the sum of five thousand dollars for the establishment of a medical library in Indianapolis. After some delay, caused by legal considerations, this library was established under the control of the Indiana Medical College of Indianapolis, which later, by merger with other medical schools, became the present Indiana University School of Medicine. A number of much-worn volumes on our shelves today bear the book plate of the "Bobbs' Memorial Hall and Library."

Present Library

The library now numbers 23,000 volumes. A total of 370 periodicals are regularly received, including the most important medical journals of nearly all of the foreign countries. The necessary curtailment of library appropriations, coupled with the rising prices of some excessively costly foreign periodicals and the present increased cost of foreign monetary exchange, has this year made necessary the discontinuance of several of the most highly priced German journals. All periodicals of importance are bound or are to be bound, and these add a yearly increase of about 500 volumes to the library. During the current year restricted funds will not allow any large addition of books and monographs.

There are now about 600 sets of journals on the shelves, of which a good proportion are complete and the gaps in the others are being filled as opportunity occurs. Although the library can now furnish from its own shelves more than four-fifths of the references desired, the requests of borrowers require us to ask frequent loans from other libraries. The number of such loans (usually of journals) is showing a steady increase, and the repeated requests for certain journals indicate what additional material should be purchased.

The chief use of the library is by local members of the medical profession as well as by faculty and students of the school. The number of library patrons has shown a steady increase, the circulation for the past year having been twenty-eight per cent greater than the year previous, and in recent years the annual gain in use has varied from fifteen to fifty per cent. In addition to the local circulation the individual out-of-town borrowers are more numerous, such loans being made only through the public or university library most convenient to the borrower. Our loans to other medical libraries also have increased considerably in the past year; these loans usually are to the libraries of other state universities. The use of the library is not wholly confined to the medical profession. Not infrequently attorneys ask to examine the latest medical literature, and sometimes desire to consult special textbooks of a considerably older period. Representatives of manufacturing industries, not of pharmaceutical supplies alone, often come with requests for literature not otherwise locally available.

The increase of circulation is due mainly to the growing capacity of the library to supply the needs of those who have occasion to consult its material. Our circulation statistics do not include the reading room use of current periodicals, the use of reference works on the open shelves, or the stack room use by those having access to the stacks. The circulation statistics of any library vary from year to year, and while such figures are the usual and most available means of measuring the service of a library to its public, the annual circulation should not be the sole criterion. A medical library should serve its patrons in other ways than by a mere delivery of books from the shelves to the borrowers, and we look forward to a time when such additional services may be afforded much more fully than now.

The library has received from private sources numerous gifts of books and other medical material, several of which have been of very notable importance. There must be in Indiana many volumes by early American and foreign writers which are interesting as to showing the advancement of medicine, but which are of no practical value to the owners. No doubt there are scores of cupboards and attics in the offices and homes of the physicians of the state containing such old books, old medical and surgical instruments, perhaps old portraits or engravings of medical significance, very old office accounts, case histories, or other relics of Indiana's medical past. All of these will be of increasing interest as the years pass and should be placed in a medical museum. The library of the Indiana University School of Medicine has a substantial nucleus of such a collection of books, instruments, and souvenirs of early medicine, and we ask the cooperation of the profession of the state in securing for permanent preservation the many such items of medical interest that otherwise may ultimately be discarded as worthless. Our library will gladly give such memorabilia a home safe from the dangers of fire and neglect.

Indiana Medical Publications

There have been a surprising number of medical journals published in Indiana since medical practice began within our borders, and of many of these there appears to be no complete file in any library in the country. We wish to secure all of these journals in order to make the medical history of Indiana as complete as possible. Of many of these local journals we do not have one volume, and of the others our files are far from perfect. We even lack a part of Volume 3, 1910, of the *Journal of the Indiana State Medical Association.* Our file of the *Transactions of the Indiana State Medical Association* is complete only from 1868 to 1907, and we have not yet been able to secure the transactions of 1849-1867. It is hoped that friends and well-wishers of the library may enable us to acquire complete files of all the periodicals to which our early practitioners contributed, and also other journals of the early days. No journals of any date or in any language are unacceptable unless it be the recent volumes or numbers of the *Journal of the American Medical Association,* which come to us frequently. Volumes of journals duplicating what we already have are always welcome for the opportunity they offer us of exchange with other libraries. Our state journal is particularly welcome for that purpose.

Biographical Reference Works

The library is, of course, fully equipped with biographical reference works such as the Quarterly Cumulative Index Medicus, the older Index Medicus, the Index Catalogue of the Library of the Surgeon-General's Office of the U. S. Army, Ars Medici, etc. The former is necessarily the most used, so constantly used, in fact, that the later volumes of the file require rebinding in less than a year's time and in the future our patrons will require a duplicate reading room set. As copies of all medical indexes in the reading room are on open shelves numerical statistics of their use are not available, but it is safe to say that the demand for them has increased considerably more than tenfold in the past four years.

Our library is located on the main floor in the west wing of the medical school building at the western end of North Street, in Indianapolis, and on the campus of the Indiana University School of Medicine and Hospitals. We extend a cordial welcome to all who may have use for the facilities of the library. Our shelves hold many journals and texts that perhaps are not to be found elsewhere in Indiana, and we ask the generous patronage of the medical profession.

Medical Economics Gleanings

"In this time of world crisis and social discontent the pressure toward socialized medicine and placing physicians on a salaried basis becomes more persistent. However, we can assume that the great majority of physicians still persistently maintain and support the principle that the practice of medicine is an individual responsibility, the individual to be free to choose his own physician and the patient should compensate his physician in proportion to the services rendered. I believe that many of us are of the opinion that there are entirely too many doctors influenced by the sentiment that almost anything would be better than the present conditions and are lending a sympathetic ear to the enticements of a determined regular monthly or annual fee for services, thus divesting the doctor and the patient of any guise of personal relationship. About the only effective weapon against this trend to socialized medicine is a healthy, wholesome state organization with its component county and city societies. The state organization is dependent upon its various committees for effective results and the committees can function properly only by having a full and active membership." —*Address of President-elect W. L. Allen, M. D., Missouri Medical Association, May, 1933.*

"... While money is a good thing to have, still, all the money in the world cannot reduce a blood pressure that is too high because of over-work." —*Vanderburgh County Medical Society Bulletin, July, 1933.*

If meddlesome outsiders would quit telling the doctors how to practice medicine, the public would be better served and the economic balance would not so often be out of true.—*Dr. Emmet Keating, Clin. Med. and Surg., Aug., 1933.*

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NOVEMBER, 1933

EDITORIALS

THE MALPRACTICE BUGABOO

The rapidly increasing list of malpractice suits against physicians demands more than passing notice; it calls for drastic action, lest it become dragon-like and prove a veritable scourge. We have had several comments on the situation lately, but seemingly these have been to no purpose, for the evil continues to flourish at an amazing pace.

The Indiana State Medical Association was one of the first to enter into an organized plan of insurance against such suits. For many years it carried on quite successfully and with a minimum of expense; in fact, we built up a sizable surplus, on a basis of seventy-five cents per member, per annum. However, with the rapid increase in such suits, it now seems we may have to attack this reserve in order to carry on. Certainly the per capita assessment is small enough, and with the proper degree of cooperation from our membership there should be no occasion for an increase.

Northwest Medicine, for October 1933, directs the attention of its readers to a few salient facts regarding malpractice suits. After considering the matter of increase in their number, the editor goes on to give what we believe to be some very wholesome advice as to the method used in combating them. He suggests a special investigating committee, appointed from the local society, whose duty it shall be to make a thorough investigation of the affair; he clearly points out that *it should not be left to the secretary of the local society.* This committee first consults with the physician threatened with a suit. The merits of the case are carefully gone into. Then the attorney about to bring the suit is consulted and the position of the committee made very clear. If a fellow physician is to appear as a witness for the plaintiff, the committee seeks him out and has a cold turkey talk with him. All this would seem to be designed to try the case ere it gets to court, which sounds as though it might be good doctrine.

Whatever merit there may be to the plan, we have long been of the opinion that not enough activity is displayed by the county society in these cases; our observation has been that a lot of sympathy is expressed for the defendant and that just about concludes the manifest interest usually displayed.

Some time ago we commented on a case in which a legal firm was consulted by an "aggrieved" patient, seeking damages in a rather large amount. This firm consulted with several local physicians, all of whom, save one, advised that they keep out of it, which action they decided on. We thought that would end the matter. However, another attorney took the case, made the proper filing and even went to suit. Some legal complication or other arose, following which this attorney decided to step out, which he did. Lo and behold! A third attorney interested himself in the case, filed a new suit, and a date was set for the hearing. This third attorney, wishing to be duly fortified, wanted to get a copy of the hospital record, so set about it by having a doctor in that community request the privilege of looking over the hospital record, and that doctor did make such a request! However, he was denied access to the record. The defendant doctor approached the doctor who had sought to see the hospital record, who remarked that his testimony would probably not hurt the defendant. Just what was meant by that we, of course, do not know, but we do hold the opinion that it would have been just as well had he not entered the case. The finale of this third chapter came just a few days ago when the defendant doctor called to tell us that the suit had been dismissed.

Several morals might be written for the story, all of which would point to the fact that physicians approached by attorneys looking for medical support in their malpractice suits should be more than commonly cautious. Another is that had a local committee properly gone into this case at the beginning, there is a very strong possibility that the suit would never have been filed.

We again urge that something definite, something radical, if you please, must be done about this thing; we cannot longer sit idly by and permit this evil to grow, unhampered; the remedy lies solely within the hands of organized medicine; it is to our leaders that we must look for a solution of the problem and a direct application of that solution.

THE SPECIFIC PRESCRIPTION

It takes a physician a long time to acquire the knowledge which permits him the responsibility of writing a prescription. He puts on this piece

of paper the authority for a licensed pharmacist to deliver to a patient drugs which are potentially dangerous or worthless if not correctly compounded or directions not conscientiously followed. The physician's reputation is not infrequently carried in this slip of paper. It should be a specific order, and not one to be filled at the choosing of anyone else in any other way except as intended.

One wonders if the telephoned prescription is as desirable as convenient. It is interesting that we hear of cult practitioners, unable to write prescriptions, calling a drug store by phone, announcing themselves as "Doctor" So-and-So and ordering medicinal remedies for their retainers. Are not the aspirations of these self-styled drugless-healers remarkable?

It is to be assumed that the writer of the prescription understands explicitly the nature of the drugs for which he writes. This means that he knows the origin and preparation of the individual constituents of a prescription. All pharmaceutical houses do not prepare drugs in a like manner. Every tincture or fluid extract of a drug is not the same. Not all ergot or digitalis preparations are alike. Not every one-grain tablet of thyroid or one c.c. of pituitrin is equal in all respects to another put up by a different firm. Many firms make only a few preparations to which they give the most painstaking care. It is possible that they may have processes and qualifications superior to a firm making a complete line. Physicians soon become familiar with the nature of certain preparations and rely upon them. Undoubtedly many competing preparations do not give the expected results.

Research is an expensive part of a firm's business and those carrying on extensive research usually put upon the market superior products. These firms keep their products, already on the market, up to standard and produce and release only new products of proven, rather than theoretical value.

The Council on Pharmacy and Chemistry does a great service in investigating the worth of pharmaceuticals and approving of the honesty and virtue of the manufacturer's claims. Your Journal takes care to advertise only products of accepted honesty and virtue. You are doing your patient, yourself and THE JOURNAL a service by specifying such drugs.

With very little extra trouble when writing a prescription one can specify the preparation he specifically wishes, and he has every reason to expect that the specified preparation will be dispensed.

THE INDIANA PLAN

THE JOURNAL has had much to say recently anent the new set-up in the Indiana State Board of Health, which has come to be known as "The Indiana Plan." We have tried to make very clear the part that the Indiana profession is expected to play—*must* play if the plan is to be the success it deserves to be—but it seems there is yet some misunderstanding as to just what is expected of us.

No radical departure from time-worn custom has ever been made without arousing some degree of criticism, if not animosity, and this is certainly true in the present instance; there is criticism, of course; there is more than criticism, there is an attack being made that smacks very strongly of sniping, and we are very frank to say that we are not overly fond of snipers.

However, no doubt now remains as to the success of the plan, as it is becoming more and more evident that the members of the Indiana profession are eager to take over the work that rightfully belongs to them—the guardians of the health of our own people. We do not mean to infer that this privilege had been wholly denied them under the old regime, but the fact remains that the medical profession of our state had but little to say regarding health matters. We recall an instance when a former state health officer, addressing a group of officials of our Association, reminded them that there was no connection between the Indiana State Medical Association and the Indiana State Board of Health; moreover, it has commonly been proclaimed, and this rather directly from the State House annex, that the two organizations had nothing in common. Indiana physicians have long resented this; they have been more than displeased with the ever increasing activities of certain departments of the State Board of Health, and now that an opportunity is afforded to take over much of the work that rightfully belongs to them we have no doubts as to the success of the undertaking.

It has been correctly stated that there are three major groups that should have control of health matters in Indiana: the Indiana State Medical Association, the Indiana State Board of Health and the Medical Department of Indiana University. Of course there are other smaller groups, such as the Indiana Dental Association, the Indiana Nurses' Association, and probably several others, but the three first mentioned should bear the brunt of health education and preventive medicine.

This is no new situation; we should have had the closest cooperation between these three groups long ago, but for one reason or another they have never been able to get together. Some time ago there was published in THE JOURNAL a graph showing the set-up as at present in force; it showed how intimately the various factors were connected, a complete interlock, if you please. It might be well to turn to that page again and refresh your memory on that point.

From conversations with several of those in authority we gather that the various county societies are being asked to indicate just how far they may be expected to cooperate; we are advised that as yet not one society approached has indicated that anything but complete cooperation may be ex-

pected. Infant hygiene and maternal welfare seem to have been one of the chief bones of contention during the former regime, many of the profession feeling that these departments went too far in their enthusiasm to do things. Dr. A. M. Mendenhall of the Department of Obstetrics in the Indiana University School of Medicine has already worked out a plan whereby the various county societies can and will carry on this work to a better advantage than before.

Just at the present moment the thing most needed is support of those in authority. They have laid all their cards on the table; they have a most excellent plan; and they are ready to go. The Indiana State Medical Association, together with all its component societies, should ride along with them.

LAKE COUNTY MEDICAL RELIEF

Up in Lake County, where the indigent medical relief problem has been a bone of bitter contention these past three years, it now seems that a settlement of the problem is in active progress, and is due to the activity of Mr. William H. Book, director of the Governor's Relief Commission. Prior to a year or so ago, the local trustees appointed township physicians and paid all bills on a fee basis. These bills mounted with an amazing rapidity as the years went by, until they reached such stupendous sums that the attention of the public was attracted thereto, whereupon a great hue and cry arose and the matter was officially investigated. This check-up resulted in what amounted to a local scandal, as a result of which officials as well as doctors and dentists were indicted, following grand jury investigations; two convictions were had, both of which have been appealed to the higher courts. Some time ago the trustees of North and Calumet townships, the populous centers of north Lake County, entered into contracts with a single physician in each township, agreeing to pay the somewhat sizable monthly salary of $2,500, this to include all medical and surgical attention, but not the hospitalization charges. The plan proved quite unsatisfactory, as was evidenced by the many complaints on the part of several most vitally concerned and, as a result of a study of the problem, Director Book has already entered into a contract with the Calumet Township Medical Society, paying a gross monthly sum of $1,700 for this work. The Calumet township group has perfected an organization to take charge of the matter and has arranged the work on the unit basis. None but members of the society are permitted to participate in the work. Plans are now in the making to institute a similar program in North township and it remains to be seen just what the ultimate result will be. At any rate, the matter of indigent medical relief is now in the hands of the medical profession, insofar as it relates to Lake County.

EDITORIAL NOTES

DEAR DOCTOR:

THE JOURNAL and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospitals.

We invite and urge you to use this Service.

It is absolutely *free* to you.

The Cooperative Bureau is equipped with catalogues and price lists of manufacturers, and can supply you information by return mail.

Perhaps you want a certain kind of instrument which is not advertised in THE JOURNAL, and do not know where to secure it; this Service Bureau will give you the information.

Whenever possible, the goods will be advertised in our pages; but if they are not, we urge you to ask THE JOURNAL about them, or write direct to the Cooperative Medical Advertising Bureau, 535 N. Dearborn St., Chicago, Illinois.

We want THE JOURNAL to serve *you*.

IT is to be hoped that our Executive Committee, mindful of weather conditions usually prevailing during the latter part of September, will make suitable changes in the date of our annual meeting next year. While at French Lick we heard many comments to this effect, which are herewith passed on to that committee for their earnest consideration.

THERE is being published in New York a publication that is called the "National Recovery Survey." It advertises a list of publications concerning the activities of the NRA and other subjects connected therewith, but the official NRA has no connection with any of these publications. Although bedecked with blue eagles and national colors, the "National Recovery Publications" has no relation to any federal authority.

WE have been advised that a man is soliciting in Indiana, attempting to sell life insurance in a company called the Insurance Company of the American Medical Association, supposedly sponsored by the A. M. A. The American Medical Association is not sponsoring any life insurance company anywhere in the world and any statement from any source to the effect that the A. M. A. is concerned in any manner with the sale of insurance policies is without foundation in fact.

ANOTHER change in our annual program that might well be considered is that of holding the annual banquet before the last night of the session. For the past two years there has been a general exodus of members during the last afternoon of the session, making for a limited attendance at the annual dinner. It is our observation that dinner attendance is markedly stepped up if said dinner is held earlier in the session. We offer this suggestion to the program committee in making their arrangements for the 1934 meeting in Indianapolis.

IN the Missouri State Medical Journal for October the editor comments on his State Association and the Missouri State Board of Health, his editorial being entitled "State Department of Health Invites Cooperation with State Medical Association." We quote: "For a good many years the State Medical Association has offered its services to the State Board of Health, but until now no specific plan has been devised by which the board and the Association would be intimately associated in the study of the many health problems that confront the board, the Association and the people." Evidently Missouri has found herself in a situation such as has existed in Indiana for many, many years, a situation that now bids fair to be remedied through the new set-up incidental to the Indiana plan.

ON a recent Sunday night, after we had listened to the address of President Roosevelt, the thought came to us, as it has on the occasion of his former addresses to the radio audience, "Well, the President of the United States has just been our guest; he walked in, sat down, and had a most intimate chat with us; and, gosh! how we did enjoy his little visit!" Regardless of politics, regardless of whether or not we voted for him, President Roosevelt has found the way to the hearts of his people; one cannot listen to these intimate chats without the feeling that the speaker is most sincere, and that he is bending every effort to restore the nation to its former state. In our memory no former President has so successfully entered the very homes of the nation.

WITH the close of the year in the offing, when most of our societies hold their annual elections, it might be well to mention the importance of at least two of the officers to be named—the secretary and the delegate to the annual meeting. A medical society without a live secretary is just like a rudderless ship; it may go along, after some fashion or other, but it will not have any great degree of accomplishment at the close of the year. If your present secretary is functioning properly and efficiently, by all means re-elect him; keep him in office just as long as he will stand for it, for you may not choose a man equally good as his successor. The same applies to your delegate and your alternate; if they are up and doing, attending our annual sessions, keep them on the job. Pass around the other offices, but by all means hold on to good secretaries and delegates.

THIS from the personal column of an Indianapolis paper: "Barbers—Those failing passage State Medical Test may have Blood completely restored within ten to fifteen days by New Fever Treatment. Negative test or No pay plan. Only limited number treated during October. Call ——— for appointment." Thus does an Indianapolis "chiro" put the G. U. men of our profession directly on the spot! We submitted the above to a "straight" chiropractor of our acquaintance, who at once characterized it as a lot of bosh; in fact, his comments were such as to preclude their passage through the mails. And the chap thus advertising, during the days when the drugless amendment to our medical law went through the process of enactment, barged about the State House declaring for nothing but "straight chiropracty!" The depression seems to have hit him also, that in such a short time he would engage in such advertising.

WILL J. MAYO, addressing the staff conference at the Mayo Clinic,* discusses economic conditions in Europe as he observed them on a recent visit to that country. After a brief but interesting review of the histories of many of the countries under discussion he comments sagely on the part these nations played during the World War and has somewhat to say regarding the matter of post-war settlements. The conclusion of his address is of more than passing interest when he says, "93 per cent of the business of the United States is done in our own country; we have risked too much for the other 7 per cent in foreign lands. The time has come when we must mind our own business and, above all, develop sufficient means of national defense. If we do this there will be no desire for war against us by any nation." Evidently Dr. Mayo devoted not all his visit to a study of medical and surgical conditions in Europe; his mind must have been engaged in matters economic. We are quite in accord with his observations.

THE efforts that are put forth by Dr. Morris Fishbein in behalf of organized medicine cannot be appreciated unless one has the opportunity of hearing him and seeing him in action, as he appeared before the American Public Health Association meeting in Indianapolis recently. His talk was presented before an audience which was decided in its views against the medical profession, almost to the point of hostility. The health officers flooded Dr. Fishbein with questions which showed an opposition almost unbelievable on the part of many salaried public health officials toward the members of the medical profession in private practice. Dr. Fishbein's paper brought out the fact that the patient-physician relationship should be maintained, and, in the discussion which followed, the paper was held up to ridicule by a number of the leaders of the public health group. Although no formal action was taken concerning the so-called Indiana Plan whereby an attempt has been made to place the responsibility for public health education in the hands of the individual physician

* Proceedings of the Staff Meetings of the Mayo Clinic, September 13, 1933.

where it belongs, the air was filled with criticism on the part of the public health officialdom who attended the convention. It goes without saying that Dr. Fishbein upheld the rights of the individual physician in preventive medicine and recommended a logical step in making a plea for a better understanding between the organized medical profession and the American Public Health Association concerning these controversial matters.

THE lay press continues to show an increasing interest in the economic status of our profession. The following is noted in the Michigan City *News*, of September eighteenth:

"*Doctor's Pay.* Physicians in Telfair County, Georgia, have joined forces with the worm that turned. They put a signed statement in a local newspaper warning patients behind with their bills that from now on medical service was to be on a cash basis.

"The doctors justified this drastic action with the fact that their financial difficulties were taking too much time from their work. For four years they have given their services generously. They have extended credit. At the same time, their own bills have had to be met. The doctors say they have 'borrowed, gone into debt, and are on the verge of having to beg.' It is a situation not peculiar to Telfair County or to Georgia. Doubtless doctors in every county in the United States have had this experience in varying degrees.

"The Georgia group add that they have no desire to mistreat anyone or neglect their duty, but they have observed some delinquent patients spending money for 'unnecessary pleasures,' paying up other bills and letting the doctor's go. The doctors not only consider it their turn for a little remuneration, but fear they themselves will be 'on the town' soon if something is not done about paying them.

"Outsiders may wish the doctors success in their future collections, and also recommend that they look into some of the group payment plans for medical service which are coming to many parts of the country today."

COMES now the season for fall festivals, church bazaars, ladies' aid society cookbooks and whatnot, all of which means the poor professional man ("poor" used advisedly) is solicited with a view to inserting his professional card in these various pamphlets, booklets, or directories. Up South Bend way the ladies of one of the churches of the community were successful in getting twenty-three medical men to fall for the racket, this in addition to a sizable list of dentists, lawyers, and other professional men. To our notion this is a waste of money, since "advertising" of this sort is usually unproductive, except that it may be worth while to the few of the profession who like to see their names in print, regardless of what print it may be. The chief fly in the ointment, however, lies in the fact that one is "helping" these various organizations very little when subscribing to such appeals, for practically all such schemes have professional promoters behind them. In the South Bend instance it seems that the church organization mentioned received "a per cent" of the net profits, the remainder of the money going to promoters who live elsewhere. A short time ago the professional men of our community were canvassed by telephone and were asked to participate in a business promotional scheme, based on a slightly different version of the "trade dollar" plan so commonly used a few months ago. It now develops that the campaign was a decided flop and, because of the fact that the sponsor organization had signed a contract, members of the legal profession were asked to bring suit against the sponsors for an alleged abrogation of contract. When you are approached for a contribution or solicited for advertising in such schemes, make inquiry as to the Senegambian in the woodpile; he usually is there.

AT present writing it seems not to have been determined just how NRA is to affect the medical profession, but one of its chief features has a strong appeal to us, that of limitation of working hours. For many years we have preached the gospel of temperance, in the matter of office hours, but most of the seed has fallen on barren ground. We recall that several years ago the physicians in our community were veritable office slaves, working six nights each week and a half day on Sunday. When a movement was inaugurated looking toward a reduction of hours, including the elimination of Sunday hours, practically all the physicians of the community signed up. However, there were two or three "chiselers" who promptly cheated, they being of the grasping type, and carried on with drawn blinds on the nights that were to be "free nights." Later a few brave souls dared to take an afternoon off and, after quite some time, Wednesday afternoons were almost universally given over to various forms of relaxation from office cares. We recall that predictions were freely made that these doctors would soon lose their business being away from the office a whole afternoon each week! But, strange to relate, they did not; rather were they better enabled to carry on an increasing business because of the little weekly vacation. They enjoyed life as never before, and became better acquainted with their families. So far as we know there is no justifiable reason why any doctor should be in his office every evening; two or three night hours per week will take care of all the business that comes in. However, again referring to the "chiselers," a little coterie is always to be found who will take advantage of the other fellow's absence. This is the type of parasite who stays away from medical society meetings, annual picnics, and annual dinners solely because he hopes thereby to grab off an extra patient or so. If the NRA teaches the medical profession but this one thing, that it is just as well to take a little time off for one's self and family, it will have accomplished much.

THE PRESIDENT'S PAGE

CHILD HEALTH RECOVERY CONFERENCE

WASHINGTON, D. C., OCTOBER 6, 1933

Conference called by Secretary Frances Perkins and conducted by Grace Abbott was very well attended by delegates invited by Miss Abbott and a number of uninvited guests, among the latter of which I was numbered.

Upon request of the Executive Committee, I attended.

The meeting was opened by Secretary of Labor Frances Perkins, who delivered a message of welcome from the President and urged the necessity of increased efforts to allay and overcome the increase of malnutrition among children. Especially she stressed the point of the increase among children of the heretofore non-dependent family.

A statement of the purposes of the conference was set forth by Mr. Hopkins, in which it was declared that practically an emergency existed in the great increase of undernourishment of both pre-school and school age children; that the White House conference called by Mr. Hoover in 1930 showed 6,000,000 undernourished, and that the number had greatly increased; but while no exact number could be stated, the estimate would probably come near 11,000,000, and that every available resource of relief, with cooperation of all agencies from local to federal, would have to cooperate on the health recovery plan.

A report of the Executive Committee of the Children's Bureau of the Department of Labor was made in which a plan was proposed to accomplish the above results.

Mrs. Roosevelt spoke for a few moments on the general outlook, the necessity of cooperation, and the need of education of both mother and children in the general health movement. She also in her remarks left the impression of an undercurrent thought of federal prenatal activities, which makes one wonder how active this movement may prove in the next congress.

Miss Grace Abbott, director of the Children's Bureau, was general chairman. She is of the dictator type of presiding officer, and, while she asked for criticism and opposing views, she did not hesitate to interrupt a speaker to voice her own views or to call time on a speaker who had independent suggestions not wholly in tune with her composition.

Much diversity of opinion was disclosed.

In spite of the testimony of physicians from many parts of the country, in spite of the low infant and childhood mortality rate, in spite of the vital statistics reports showing a low incidence of nutritional and infectious diseases among children, in spite of the opinion of many health officers and social workers that malnutrition had not materially increased, if at all, and in spite of the reports from many states that malnutrition among children had greatly decreased, Miss Abbott declares that the Children's Bureau and Department of Labor has decided otherwise.

Miss Abbott announced several times that she wanted criticism and suggestions on the plans submitted by the Executive Committee, but I wonder if this was strategy for the purpose of discovering opposition and better preparation for combating it!

The sentiment was expressed by several that harm rather than good would come from propaganda publicity.

It was also decided to call the movement "Child Health Maintenance" and not "Child Health Recovery." This she accepted after sharp discussion.

The plan follows, in many respects (leaving out of consideration the actual relief activity), that adopted by Indiana in its general public health program; that is, education, all in cooperation with the physician. I am pleased to add that advice was given not to disturb but to encourage the patient-physician relationship, and especially so among the type of needy whom I have been designating as the acute indigent, in contradistinction to the chronic indigent who are now giving us comparatively little concern.

All in all, I was pleasantly surprised at the attitude of the federal officers. While they insist that this shall be more or less directed by the Children's Bureau, yet they advise that these problems be worked out by each individual state and in each individual community. They admit many states do not need federal aid nor federal supervision on this problem; still they intimate that their weather eye will be directed in forty-eight different directions.

New Jersey made a report in which was set forth a plan very similar to the Indiana plan.

In a private conversation with Miss Abbott, Indiana came in for some favorable comment, in which she commended the spirit of cooperation of the medical association in the public health program.

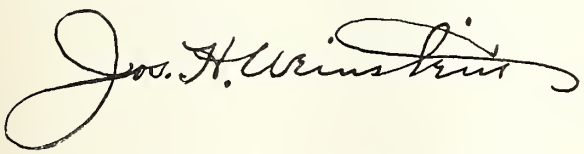
The Parent-Teacher Association, working in connection and in harmony with the medical and nursing professions, was stressed as being probably the greatest and most efficient way of education of mothers and children in hygiene and diet.

I am convinced that some of the powers-that-be have seen the errors of their ways and realize that no health plan to be successful can be carried on without the willing cooperation of the organized medical profession, and that the medical profession cannot be coerced into doing its part without being given rightful recognition and an opportunity to have its say in the direction of health activities.

This is as it should be and is only just now slowly coming about since organized medicine's awakening to the realization that the practice of medicine was being mechanized by socialistic-minded individuals, and that the physician's rights to practice and to be master of his soul were being insidiously taken from him.

The answer to the entire question is organization and the impression on the layman of the fact that for the benefit of the people and the advancement of scientific medicine the physician must remain individualistic, and that no intermediary agencies of any nature whatsoever can step in between physician and patient.

While everything on the surface seemed quite satisfactory and innocuous, it behooves the profession to be alert and on the watch to see that a wolf in sheep's clothing is not stalking among us, and that the permission of *local option* does not follow the same course that resulted in the 18th Amendment.



SECRETARIES' COLUMN

Now that the French Lick session is over, and everyone had a good time, and the new president-elect has been elected, it is time to begin to think about the secretaries' conference to be held next January. We want to make this the best meeting ever held. Suggestions about the conference will be gladly received; please send them in; the committee wants them.

Congratulations to Dr. Leach, the new president-elect. Let every secretary give him support so that the good work that the State Association has been doing will keep going.

"One Man's Journey," a motion picture starring Lionel Barrymore, is a great message against state medicine. If you have an opportunity to see it, do so. This method of combating state medicine is a wonderful adjunct. If it could be developed the medical profession could show more people what the family physician means than in any other way.

Last week a conference was held in Washington, D. C., on child welfare (malnutrition). This was conducted by Miss Grace Abbott. Her plans were somewhat upset by the medical profession. If she has her way we will soon have another law similar to the Sheppard-Towner Bill.

It is understood that several influential health officers in the U. S. think that the Indiana plan is wonderful, and that they are going to try to get such a plan in their own states. It is up to our county medical societies to put this thing across. Do not neglect the rural communities. Go out and put on these meetings before someone asks you to do so. A good plan would be to have several small meetings and then one large meeting in each county. There might be one talk for the Rotary, one for Kiwanis, one for Department Club, one for American Legion, one for Parent-Teacher, etc.; then one large meeting for everyone. If you will notify Dr. Gatch about the large meeting he will help you put it on in several ways. All these things will help defeat state medicine and will show that White House conferences are not necessary because the health of the state is being taken care of from every standpoint.

With every medical society working as a unit and not as individuals, as it was stated at French Lick, we will be able to keep the standard of medicine on the highest level.

A. M. MITCHELL, *Chairman.*

DIPHTHERIA REPORT FOR SEPTEMBER, 1933

Six deaths in the month of September show a slight increase over August, but no more and perhaps not quite as many as were expected. To date there have been seventy-one deaths for the year, which is an excellent record as compared with other years; but the fact that there are several diphtheria epidemics in the state leads us to look forward to the next three months with a considerable degree of concern. Recently there have been epidemics around Brookville, Lafayette, Clark's Hill, Greenfield, and Bloomington, and sporadic cases have been noted in various counties rather widely distributed over the state.

The months of October, November, and December almost invariably are the heavy months for diphtheria deaths. We have an excellent chance of holding the death rate to a new low level this year, provided there are no more than an average of twenty-two deaths a month during the next three months. It is not unlikely that this number will be approached. When considering that this would amount to considerably more than one death for each school day for the remainder of the year, we have it brought to us that diphtheria is still a menace in Indiana. For the last three months of 1932 there were seventy-one deaths; for the corresponding period during 1931 there were sixty-six deaths, and in 1930 there were forty-six deaths during the last three months of the year. A kid-

napping gang that would abduct one school child a day for the remainder of the year would call out the United States army, if necessary, to suppress it. Diphtheria may take that number of children and should call out the concerted efforts of the medical and teaching professions in order that such a catastrophe may be averted.

Efforts are on foot for an immunization campaign which should go a long way toward holding down diphtheria, but which will, of course, have little or no effect on the three high months immediately in the future.

Below will be found a list giving the distribution of deaths for September and for the year 1933 so far.

County	Total for 1933	September 1933
Allen	9	0
Bartholomew	1	0
Blackford	1	0
Daviess	2	0
Delaware	1	0
Dubois	1	0
Fayette	2	1
Fountain	1	1
Fulton	1	0
Gibson	1	1
Greene	2	0
Hancock	2	0
Harrison	1	0
Howard	1	0
Jackson	2	0
Knox	1	0
Lake	2	0
Lawrence	2	0
Madison	1	0
Marion	8	0
Monroe	1	0
Morgan	1	0
Noble	1	0
Orange	1	0
Parke	1	0
Pike	1	0
Randolph	1	0
Ripley	1	0
Shelby	2	0
Starke	1	0
St. Joseph	1	0
Sullivan	3	0
Switzerland	1	0
Tippecanoe	3	0
Union	1	0
Vanderburgh	3	2
Vigo	1	0
Warren	1	0
Warrick	1	0
Wayne	2	1
Wells	1	0
	71	6

VOICE OF THE DOCTOR

PITUITARY SOLUTIONS IN LABOR

September 28, 1933.

To the Editor:

Recently I have been repeatedly informed that I am being quoted as having lost some of my fear of the use of pituitary solutions in labor. I have now before me a letter from a physician in the northern part of the state informing me that a representative of a chemical company had just been in his office and said that, "Even Mendenhall is beginning to admit that thyotuitary has its merits."

This is absolutely misleading and a misrepresentation of fact.

There is not an authentic article in print which proves that thymus extract added to pituitary solutions removes the real dangers. On the other hand there is abundance of proof that any or all of the products which combine thymus and pituitary extracts are merely pituitary in disguise.

Dr. M. Pierce Rucker of Richmond, Virginia, two years ago gave thymophysin a very thorough tryout, clinically and experimentally, and found its action the same as pituitary alone.

Drs. H. W. Schoeneck and F. J. Schoeneck of Syracuse University also used it on 35 cases and said that "less than one-fourth of the recommended dose produced violent uterine contractions."

DeLee, in his 1933 textbook, says (page 621), "Thymophysin carries identical disabilities with pituitary."

A few months ago Dr. DeLee felt compelled to state in the *Journal of the A. M. A.* that these manufacturers were falsely stating that he approved their preparation and that he desired that the medical profession should know he did not.

My own feeling has not changed since the publication of my article, "Solution of Pituitary and Ruptured Uterus," in the *Journal of the American Medical Association*, April 20, 1929. With the great train of disasters being recorded in the medical literature in opposition to pituitary solution, we are happy to note a falling off in the sales of this dangerous drug. The less scrupulous of the manufacturers (there are several in the list) are endeavoring to obscure and disguise the real dangers. Adding thymus extract to the pituitary solution adds to the volume only, not to the safety. Nor does the removal of the blood pressure element from the solution (this is done by one company) make it appreciably safer, as the oxytocic quality is the real danger.

A. M. MENDENHALL, M. D.,
Indianapolis.

APOMORPHIN IN PAROXYSMAL TACHYCARDIA: A CLINICAL NOTE

A scanning of the literature fails to reveal reference to the use of apomorphin in paroxysmal tachycardia. However, the drugs conventionally used, such as quinidine, for example, do have emesis as a conspicuous feature of their pharmacology. As recently as the July issue of the Journal of Pharmacology and Experimental Therapeutics (48, No. 3, 305), there is an article on "Quinidine Emesis." It is a fairly well-known clinical fact that any good vagal stimulus usually will stop a paroxysm.

The writer happens to have several patients who have recurring attacks of paroxysmal tachycardia. One woman in particular has attacks lasting as long as 26 hours about every two months. She remarked one day that if she could only induce vomiting she was sure the attack would stop. I gave her some mustard in warm water and the attack did cease with the first real retching. The mustard very much upset her stomach, so that she had gastric distress for several days. In thinking this case over it appeared obvious that there is no simpler way of causing emesis than by giving a full dose of apomorphin. Accordingly, at the next opportunity one-tenth of a grain of apomorphin was given hypodermically. The paroxysm promptly ceased with the first good antiperistaltic wave. Since then I have had occasion to use this method four times, and have found it very efficacious each time.

Professor Luckhart of the University of Chicago, to whom these observations were mentioned, thought that we are probably dealing with a vagus effect on the auricles plus the possible violent blood pressure changes which vomiting induces.

Arnold L. Lieberman, M. D.,
Gary, Ind.

DEATH NOTICES

James W. Brunker, M. D., of Riley, died October ninth, aged seventy-five years. Dr. Brunker was a member of the Vigo County Medical Society, the Indiana State Medical Association, and the American Medical Association. He graduated from the Medical College of Indiana, Indianapolis, in 1884.

Edgar R. Borley, M. D., of South Bend, died October fourth, aged sixty-two years. Dr. Borley established his practice in South Bend in 1899 and had since practiced there. Dr. Borley was a member of the St. Joseph County Medical Society, the Indiana State Medical Association, and the American Medical Association. He graduated from the Detroit College of Medicine and Surgery in 1898.

Roger S. Tea, M. D., of Lafayette, died October third, aged eighty-five years. Dr. Tea had retired from active practice several years ago. He graduated from Rush Medical College, Chicago, in 1886.

James S. Boyers, M. D., of Tucson, Arizona, for fifty years a physician in Decatur, Indiana, died October second, aged eighty-one years. Dr. Boyers served as an officer of the Indiana State Board of Health at one time. He graduated from the Baltimore Medical College in 1884.

James H. Goad, M. D., of Gary, died September twenty-sixth, aged fifty-three years. Dr. Goad was a member of the Lake County Medical Society, the Indiana State Medical Association, and the American Medical Association. He graduated from the Illinois Medical College, Chicago, in 1908.

Marena L. B. Drescher, M. D., of Michigan City, died October seventh, aged fifty-seven years. Dr. Drescher was not in active practice. She graduated from the Northwestern University Woman's Medical School, Chicago, in 1890. She was a member of the Laporte County Medical Society and the Indiana State Medical Association.

HOOSIER NOTES

Dr. George C. Porter, of Linton, has been appointed coroner of Greene County, to fill the vacancy caused by the resignation of Mr. Elmer Tannehill.

At the September nineteenth meeting of the Fort Wayne Medical Society Dr. H. S. Scott, of Madison, Wisconsin, was the principal speaker.

Dr. Walter L. Bruetsch, of Indianapolis, has been appointed a member of the Committee on Research of the American Psychiatric Association.

The regular meeting of the Sullivan County Medical Society was held October fourth, in Sullivan. A discussion of state relief work was heard.

T. J. Clutter, of Mentone, has been appointed Kosciusko County health officer to succeed the late Dr. P. G. Fermier, of Leesburg.

At the September twelfth meeting of the Whitley County Medical Society, Dr. E. L. Cartwright, of Fort Wayne, presented a paper on "Treatment of Hemorrhoids."

Members of the Dearborn-Ohio County Medical Society held their regular meeting in Aurora, October fifth. Following a dinner, the business meeting was held at the office of Dr. E. J. Libbert.

THE Terre Haute Academy of Medicine held a meeting in Terre Haute, October sixth. Dr. W. D. Gatch, of Indianapolis, presented the principal address; his subject was "Gastric Ulcer."

THE Kosciusko County Medical Society met at the Hotel Hayes, Warsaw, October tenth. Dr. A. C. McDonald, of Warsaw, was the principal speaker.

DR. ROBERT MOORE, of Indianapolis, addressed the October sixth meeting of the Howard County Medical Society, at Kokomo. His subject was "Heart Conditions."

DR. HOWARD B. METTEL, of Indianapolis, talked to the members of the Rush County Medical Society at Rushville, October first. His subject was "Allergy."

DR. A. L. ZILIAK, M. D., of Princeton, talked about "Cancer" before members of the Gibson County Medical Society at the Princeton Methodist Hospital, October ninth.

DR. LOUIS SEGAR, of Indianapolis, addressed members of the Carroll County Medical Society at Flora, October thirteenth. His subject was, "The Care of Children."

THE Ripley County Medical Society met at Osgood, October eleventh. Dr. James C. Carter, of Indianapolis, presented an interesting paper on "Infant Feeding."

THE Orange County Medical Society and Auxiliary met in the home of Dr. and Mrs. G. C. Colglazier, of Leipsic, September twelfth. The next meeting will be held in December, at Orleans.

MEMBERS of the Business and Professional Women's Club of South Bend were addressed by Dr. A. S. Giordano, September nineteenth. His subject was "Sleeping Sickness."

MEMBERS of the Lake County Medical Society met at Mercy Hospital, Gary, October twelfth, for their regular meeting. Dr. James G. Carr, of Chicago, was the principal speaker.

J. H. WARVEL, M. D., of Indianapolis, discussed "Diabetes" at the October fifth meeting of the Elkhart County Medical Society, which was held at the Coppes Hotel in Nappanee. Thirty-nine members and guests were present.

THE fiftieth semi-anual meeting of the Eleventh District Medical Association was held October twenty-fifth at Manchester College, North Manchester. A program of unusual interest was presented. Entertainment was provided for the ladies.

MEMBERS of the Delaware-Blackford County Medical Society held a dinner meeting at the Hotel Roberts, Muncie, September nineteenth. Various topics were discussed, including diphtheria immunization, care of the indigent sick, and the NRA.

DR. J. A. MEYERS, of the University of Minnesota, talked about "Childhood Tuberculosis and Its Prevention in the Schools" before the Muncie Academy of Medicine at the Hotel Roberts, October tenth.

DR. CHARLES F. BAYER, chief medical officer of the U. S. veterans' bureau in Indianapolis, has been promoted to fill a vacancy in the field division of the medical service veterans' administration in Washington, D. C.

THE Floyd County Medical Society met at New Albany, September eighth. Dr. E. P. Easley presented a paper entitled "Trend of the Practice of Medicine," which was read before the Third District Medical Society forty years ago.

MEMBERS of the Grant County Medical Society were guests at the annual meeting of the Grant County Tuberculosis Association at Marion, October twelfth. The regular October meeting of the society was cancelled.

MEMBERS of the Cass County Medical Society met at Logansport, September twenty-second. Drs. C. L. Viney, Earl Palmer, and H. G. Steinmetz discussed "Epidemic Encephalitis." Attendance numbered twenty-five.

THE Lawrence County Medical Society met at Bedford, October fourth. Reports of the French Lick session of the State Association were given, and Dr. Norman Byers, of Bedford, presented a paper on "Educational Program of Child Welfare."

THE Fountain-Warren County Medical Society held a meeting at Perrysville, September twenty-eighth. Following a banquet, a public meeting was held. The principal speaker was Dr. Dudley Dawson, of Danville, Illinois.

THE Hendricks County Medical Society met at Crawley's Hall, Danville, September twenty-second, with Dr. R. H. Moser, of Indianapolis, as the prin-

cipal speaker. Dr. Moser's subject was "Gastric Ulcer." The presentation was a lecture for the general practitioner.

THE Fountain-Warren County Medical Society met at Perrysville, October fifth. Dr. Dudley T. Dawson presented a paper, his subject being "Modern Treatment and Care of Nervous and Mental Disease." A catfish dinner was served to twenty-two guests.

A PAPER on "Detachment of the Retina" was read by Dr. D. Hamilton Row and one on "Abnormalities of the Sinuses" was read by Dr. William Clevenger at the first fall meeting of the Indianapolis Medical Society, October third. Attendance numbered approximately 150.

THE American National Red Cross asks for generous support in its annual roll call, which will be conducted from November eleventh through November thirtieth, 1933. Physicians know that a membership in the Red Cross is a practical contribution for the relief of suffering.

A NEW map of Indiana, showing all streams, rivers and lakes, has been issued by the fish and game division of the State Conservation Department. Copies of the map, which is twenty-two by thirty-eight inches, may be obtained from the fish and game division for ten cents in coin.

THE annual convention of the Association of Life Insurance Medical Directors of America met at the Royal York Hotel, Toronto, Ontario, October twelfth. Representatives of the leading life insurance companies throughout the United States and Canada were present.

DR. GEORGE CRILE, of Cleveland, presented the principal address at the first fall meeting of the Muncie Academy of Medicine, October third. His subject was "Treatment of Circulatory Neurasthenia, Peptic Ulcer, Diabetes and Epilepsy by Denervation of the Adrenals."

THE Twelfth District Medical Society and the Northeastern Academy of Medicine held a joint dinner meeting at the Gawthrop Hotel, Kendallville, September twenty-first. Dr. B. S. Cornell, of Fort Wayne, and Mr. George F. Peabody, of South Whitley, were the principal speakers.

DRS. H. R. ALLEN, Robert Milliken, and J. H. Stygall were the speakers before the Indianapolis Medical Society at the October seventeenth meeting. Subjects presented were "Talipis Valgus," "Backache," and "Bone Tuberculosis from the Standpoint of the Internist."

THE Hancock County Medical Society held its regular meeting at the Columbia Hotel, in Greenfield, September fifteenth. A symposium on "Pulmonary Tuberculosis as the General Practitioner Sees It" was presented by the Fortville members, Drs. C. E. McCord, S. W. Hervey, J. E. Ferrell, Stewart Slocum, and Dr. B. Deakyne (dentist).

THE Marshall County Medical Society entertained physicians from St. Joseph, Kosciusko, Starke and Fulton counties, at the Plymouth Country Club, October fourth. Golf was enjoyed in the afternoon and dinner was served at six-thirty. In the evening, Dr. P. E. McCown, of Indianapolis, presented the principal address.

"TREATMENT OF INCOMPLETE ABORTIONS" was the subject presented by Edward B. Markey, M. D., of Dayton, Ohio, before members of the Wayne-Union County Medical Society at Richmond, October twelfth. At the September fourteenth meeting of this society Dr. Clifford Straley, of Cincinnati, talked about the "Diagnosis, Pathology and Treatment of Common Heart Diseases."

THE Fort Wayne Medical Society at its September nineteenth meeting passed two motions: (1) that the society would do the work of the indigent in that community as it is now being done and without increased cost to the community, and (2) that the society would suspend any member of the society who underbid the society for the proposal to care for the indigent in that community.

A POSTGRADUATE pediatric course conducted by the Wabash County Medical Society, with the assistance of the Huntington, Whitley and Kosciusko County societies, will be presented November 20th to 24th in the town hall at North Manchester. Programs will be presented in the evenings. Any physician in good standing in his local medical society may attend; there is no registration fee.

MR. MARMADUKE STOOPS, of Petersburg, has a rare collection of convention badges and other interesting relics, among which is the book by Dr. Selman, "Indian Guide to Health," the first medical book published in Indiana. It was through Mr. Stoops' courtesy in loaning the book to the Bureau of Publicity of the Indiana State Medical Association that it was brought to light.

IN the October issue of THE JOURNAL officers of the Fort Wayne Medical Society were mentioned,

naming Dr. L. P. Harshman as secretary-treasurer. Officers of the society are: Dr. A. L. Mikesell, president; Dr. W. B. Rice, vice-president; Dr. L. P. Harshman, secretary; and Dr. E. L. Cartwright, treasurer.

THE Hancock County Medical Society held its regular meeting at the Columbia Hotel, Greenfield, October ninth. A symposium, "Favorite Medical Treatments for Some Common Clinical Conditions," was presented by Drs. J. R. Woods, R. E. Kinneman, L. B. Rariden, W. R. Johnston, R. N. Arnold, and C. M. Gibbs. Drs. J. E. Ferrell and Charles Titus gave their report as delegates to the French Lick session of the State Association.

IN July of this year, Professor Hajek of Vienna bade farewell to his clinic and, according to recent announcement, the Hajek clinic will be discontinued. According to the law of Austria, every clinical teacher must give up teaching on attaining his seventieth birthday; by exception, he may teach an "honorary year" after which he must resign. Dr. Hajek completed his honorary year in July. The otologic clinic will take over the work of Hajek's clinic in rhinolaryngology.

THE Regional Conference on Social Hygiene was held in Indianapolis, with headquarters at the Hotel Lincoln, October twelfth to fourteenth. The conference was sponsored by the American Social Hygiene Association in cooperation with the Indiana state and community agencies, numbering seventeen. Dr. A. F. Weyerbacher, of Indianapolis, and Mr. Albert Stump, attorney for the Indiana State Medical Association, presided at general sessions devoted to medical and legal measures.

APPLICATIONS for the position of junior graduate nurse may be filed with the U. S. Civil Service Commission at Washington, D. C., until November 10, 1933, for open competitive examinations. Applicants must have been graduated from a recognized school of nursing, requiring a residence of at least two years in a hospital having a daily average of fifty bed patients or more, not earlier than January 1, 1930. Applicants must have been registered as a graduate nurse in some state or the District of Columbia. Full information may be obtained from the Secretary of the U. S. Civil Service Commission, Washington, D. C.

AT THE convocation services of the American College of Surgeons in Chicago, October thirteenth, in the Hotel Stevens, twelve Indiana doctors were made members of the college. They are Robert Acker and Carroll C. Hyde, of South Bend; Kenneth D. Ayres, of Anderson; James A. Craig and L. J. Danieleski, of Gary; C. O. McCormick, C. F. Thompson, F. C. Walker, and H. F. Thurston, of Indianapolis; Harrison C. Ragsdale, of Bedford; A. L. Ziliak, of Princeton; and C. P. Schoen, of New Albany. Dr. William D. Haggard, of Nashville, Tennessee, president-elect of the college, and President Hutchins, of Chicago University, were speakers at the convocation services.

AT its October third meeting, the Indianapolis Medical Society passed a resolution to the effect that no member of the society may be allied with organizations whose purpose it is to supply medical service to a group of individuals unless the organization is approved by the Executive Committee of the Indiana State Medical Association, and that any member who takes part in an unapproved organization of the health insurance type shall be automatically suspended from membership in the county and state societies and cannot be reinstated until his connections with the unapproved organization are severed.

THE U. S. Civil Service Commission announces open competitive examination for Junior Medical Officer (interne), applications for which position must be on file with the Commission at Washington, D. C., not later than November 15, 1933. Full information may be obtained from the Secretary of the United States Civil Service Board of Examiners at the post office or customhouse in any city, or from the U. S. Civil Service Commission, at Washington, D. C. Competitors will not be required to report for a written examination, but will be rated on their education and experience.

INDIANA UNIVERSITY NEWS NOTES

DR. B. E. ELLIS of Indianapolis was the principal speaker at the fall banquet of the Indiana University chapter of the Phi Chi professional medical fraternity. The following medical students were announced as pledges at the meeting: Harold Oliver, Sidney Stephens, Max Mansfield, James Young, Wendell Preston, Horace Abdin and John Thomas, all of Indianapolis; Ray Julian, Heltonville; John Dale, Washington; Joe Spalding, Indianapolis; Leon Chandler, Terre Haute; L. E. Clark, Muncie.

THE INDIANA UNIVERSITY chapter of the Phi Beta Pi professional medical fraternity has announced the pledging of the following I. U. medical students: Blair Harter, Hagerstown; Jack Loudermilk, Indianapolis; Theodore Hilbish, Bristol; Paul Campbell, Elnora; Dillon Kennington, Michigan City; James Fuelling, Woodburn; Robert Husted, Woodburn; William Wood, Evansville; Clark Truesdale, Hanover; Maurice R. Kuhn, Plymouth; Louis C. Bixler, Elkhart.

FRANK SCOTT of Shelbyville has been elected president of the Skelton Club, freshman medical organization at Indiana University. Other officers elected are: Richard Swan, Indianapolis, vice-president; Joseph Larmore, Anderson, secretary, and D. D. Gill, Indianapolis, treasurer.

NEWLY pledged members of the Nu Sigma Nu professional medical fraternity at Indiana University are Charles Voorhis, Indianapolis; Frank Scott, Shelbyville; Frank Kennedy, Indianapolis; Carlos McNiell, Paragon; Richard Bloomer, Rockville; Francis Williams, Anderson; Robert Williams, Anderson; Hunter Stewart, Marion; Richard Miller, North Vernon; Don Caseley, Greencastle; Melvin Coffel, Marion; Martin Strange, Loogootee; James Moss, Terre Haute; Warren Tucker, Salem; Floyd Romberger, Lafayette; Marvin Cuthbert, Kokomo, and Larry Sims, Indianapolis.

THE faculty of the Indiana University School of Medicine and their wives entertained with a reception the first of the present school year for students entering the Indianapolis division of the I. U. Medical School. Governor Paul V. McNutt greeted the medical students. Other speakers were Mayor Reginald H. Sullivan, Indianapolis; President William Lowe Bryan, Indiana University; Dr. B. D. Myers, dean of the Bloomington division, I. U. Medical School; Miss Cordelin Hoeflin, I. U. Nurses' Training School, Indianapolis. Refreshments and dancing followed the program.

BOOK REVIEWS

BOOKS RECEIVED

FOOD, NUTRITION, AND HEALTH. By E. V. McCollum, Ph. D., Sc. D., and J. Ernestine Becker, M. A., professor and associate of biochemistry, School of Hygiene and Public Health, Johns Hopkins University, Baltimore, Md. Third edition, rewritten. 146 pages. Cloth. Price $1.50. Published by E. V. McCollum and J. Ernestine Becker, Baltimore, Md., 1933.

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THE TECHNIC OF LOCAL ANAESTHESIA. By Arthur E. Hertzler, A. M., M. D., professor of surgery in the University of Kansas. Fifth edition, with 148 illustrations. 292 pages. Cloth. Price $5.00. The C. V. Mosby Company, St. Louis, 1933.

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OBSTETRICS AND GYNECOLOGY: By 80 Leading Specialists. Edited by Arthur Hale Curtis, M. D., Professor and Head of the Department of Obstetrics and Gynecology, Northwestern University Medical School; Chief of the Gynecologic Service, Passavant Memorial Hospital, Chicago, Ill. Complete in 3 Volumes and Separate Desk Index. 3,500 pages with 1,664 illustrations, many in colors. Philadelphia and London: W. B. Saunders Company, 1933. Per set, Cloth $35.00 net.

DISEASES OF THE CHEST AND THE PRINCIPLES OF PHYSICAL DIAGNOSIS: By George William Norris, A. B., M. D., Formerly Professor of Clinical Medicine in the University of Pennsylvania; and Henry R. M. Landis, A. B., M. D., Sc. D., Professor of Clinical Medicine in the University of Pennsylvania. With a Chapter on the Transmission of Sounds Through the Chest by Charles M. Montgomery, M. D., Formerly Physician to the Phipps Institute, Philadelphia; and a Chapter on the Electrocardiograph in Heart Disease by Edward B. Krumbhaar, Ph. D., M. D., Professor of Pathology, University of Pennsylvania, School of Medicine. Fifth Edition, Revised. 997 pages with 478 illustrations. Philadelphia and London: W. B. Saunders Company, 1933. Cloth, $10.00 net.

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VISUAL FATIGUE OF MOTION PICTURES. A World-wide Summary and Survey. 48 pages. Paper bound. Compiled and edited by Aaron E. Singer, research editor, Amusement Age Library Series. Price $1.00. Amusement Age Publishing Company, New York, 1933.

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BOOK REVIEWS

FRACTURES. By Paul B. Magnuson, M. D., associate professor of surgery, Northwestern University Medical School, Chicago. 317 illustrations. Price $5.00. J. B. Lippincott Company, Philadelphia, Montreal and London, 1933.

Comfortable and profitable reading awaits one who picks up Paul B. Magnuson's work on "Fractures." Comfortable because his diction, which is unusually clear and lucid, makes for easy reading; interesting because what Magnuson has to say concerning fractures is quite worth while.

The book is not to be considered as a treatise on the general subject of orthopedics; rather is it intended for the man who has to use his own wits in the management of these frequently intractable cases. The mechanics of fracture treatment are, as might be expected, just about the last word on the subject since the author has long been known as an adept in the matter of physical appliances used in this branch of surgery.

The illustrations are numerous and very well done; the book is generously indexed and should be in the hands of all who treat fractures.

* * *

GASTRIC ANACIDITY—Its Relation to Disease. By Arthur L. Bloomfield, M. D., professor of medicine, Stanford University, and W. Scott Polland, M. D., instructor in medicine, Stanford University. 188 pages. Cloth. Price $2.50. The Macmillan Company, New York, 1933.

This is a monograph giving a large number of detailed graphs and tables depicting different phases of gastric secretion. It gives particular attention to the effects of histamine excitation. The bibliography at the end of each chapter is quite complete. The authors admit that the subject is very intangible and disclaim any notion of considering anacidity as a disease entity. "Many an essentially normal person has been badly scared into a neurosis, by being told that he has no acid in his stomach." The practical use of this book is chiefly negative in that it disproves the bizarre hypothesis held by befogged practitioners.

* * *

DISEASES OF THE HEART. Described for practitioners and students. By Sir Thomas Lewis, C. B. E., F. R. S., M. D., physician in charge of Department of Clinical Research, University College Hospital, London. 297 pages. Cloth. Price $3.50. The Macmillan Company, London and New York, 1933.

This book is designed particularly for the practitioner, and he will find that it is written in beautiful English. The sections on arrhythmias cannot be surpassed, being very similar to his earlier book, "Clinical Disorders of the Heart Beat." The chapters dealing with heart failure and coronary disease are written in a clear and concise manner. His discussion on therapy, especially the after-care of the patient, is

very instructive in the treatment of cardiac patients. The book is a very helpful and instructive text in the management of every-day problems in patients with heart disease.

* * *

CRITERIA FOR THE CLASSIFICATION AND DIAGNOSIS OF HEART DISEASE. By the Criteria Committee of the Heart Committee of the New York Tuberculosis and Health Association, Inc. Approved by the American Heart Association. Third edition. 131 pages. Cloth. The New York Tuberculosis and Health Association, New York, 1932.

This book emphasizes the importance of etiology in the diagnosis and treatment of cardiac cases. Written in a clear and concise manner, it covers the subject briefly and yet adequately. It is replete with invaluable hints and suggestions for the management of cardiac patients. This book is a helpful addition to a physician's library and is destined to be used widely as a text. It can be recommended highly to the medical profession.

SOCIETIES AND INSTITUTIONS

INDIANA STATE MEDICAL ASSOCIATION

THE COUNCIL

First Meeting

(French Lick Session, September, 1933)

The Council of the Indiana State Medical Association convened for a luncheon-business meeting in one of the special dining rooms at the French Lick Springs Hotel at 12:30 p. m., Monday, September 25, 1933, with Dr. O. O. Alexander, of Terre Haute, presiding. Roll call showed the following councilors and officers present:

COUNCILORS

1st District	John H. Hare, Evansville
2nd District	H. C. Wadsworth, Washington
3rd District	H. C. Ragsdale, Bedford
4th District	H. P. Graessle, Seymour
5th District	O. O. Alexander, Terre Haute
6th District	Samuel Kennedy, Shelbyville
7th District	L. A. Ensminger, Indianapolis
8th District	M. A. Austin, Anderson
9th District	F. T. Romberger, Lafayette
10th District	E. M. Shanklin, Hammond
11th District	E. O. Harrold, Marion
12th District	E. M. VanBuskirk, Fort Wayne
13th District	W. B. Christophel, Mishawaka

COUNCILOR-ELECT

11th District	George D. Miller, Logansport

OFFICERS

J. H. Weinstein, Terre Haute, President
E. E. Padgett, Indianapolis, President-elect
A. F. Weyerbacher, Indianapolis, Treasurer

EXECUTIVE COMMITTEE

H. H. Wheeler, Indianapolis
T. A. Hendricks, Executive Secretary

Upon the motion of Dr. Ensminger, duly seconded, the reading of the minutes of the midwinter meeting of the Council, December 1, 1932, was dispensed with as these minutes had appeared in the January, 1933, JOURNAL.

The annual councilor reports were accepted as printed in the September JOURNAL.

The secretary asked that a continued effort be made to avoid the conflict in district meetings. He stated that in general the arrangement was much better than it had been in the past but that upon one day last year two district meetings were scheduled for the same time. The suggestion was made that each councilor get in contact with the president of his district society early in the year and obtain the date of his district meeting and report it to headquarters office.

The following letter was read in answer to the question as to the relationship of the medical profession to the National Recovery Act:

> "We have received so many perplexing and conflicting statements emanating from supposedly official sources that I have come to the place where I do not know what the real attitude of the National Recovery Administration actually is."

A short discussion was held in regard to the plan whereby Federal Emergency Relief funds are made available to members of the profession. The attention of the members of the Council was called to Federal Emergency Relief Administration Rules and Regulations No. 7 governing medical care provided in the home to recipients of unemployment relief.

Dr. Alexander explained the action taken by the Council at its special meeting last year when it drew up rules and regulations for the management of THE JOURNAL. He stated that under these rules and regulations the editor of THE JOURNAL should be named at the midwinter Council meeting. However, if the Council waited until the midwinter meeting this year, which is to be held after the first of the year in order that a complete financial report for 1933 and the 1934 budget may be available, there would be a period during which there would be no official editor of THE JOURNAL. Upon Dr. Alexander's suggestion a motion was made, seconded, and carried, that the Council select the editor and the member of the editorial board to succeed Dr. Charles N. Combs at this meeting. Dr. E. M. Shanklin was unanimously re-elected editor for 1934 and Dr. L. P. Harshman was elected to membership on the editorial board to serve five years, starting January, 1934. The secretary was instructed to have the attorney for the Association draw up a contract between the Council and the editor for 1934.

New charter for the Madison County Medical Society which had been prepared at the request of the secretary of the society was given to Dr. M. A. Austin, councilor of the Eighth District, for presentation to the Madison County Medical Society.

Letter from the secretary of the Indiana Roentgen Society requesting that a change in date of the state session be made so that it would not conflict with the National Roentgen Ray Society meeting brought to the attention of the Council. The Council instructed the chairman and the secretary to draw up a resolution to be presented to the House of Delegates recommending that the date of the state meeting be set later in order to avoid the excessive heat that so often prevails in September.

Correspondence regarding a membership in Miami County brought to the attention of the Council. Dr. Miller, councilor-elect, said that he thought this matter would be definitely decided shortly.

Letter received from the Better Business Bureau asking the Association to take membership in the Bureau. The Association is now a subscribing member to the Better Business Bureau Bulletin for $5.00 a year. Membership in the Bureau would cost $7.00 in addition to the $5.00 subscription. As the Better Business Bureau is an organization local to Indianapolis, it was the consensus of opinion that the State Association should not expend any additional money for membership in the Bureau as this was a local rather than a state matter.

As the minutes of the Executive Committee meetings are now published each month in THE JOURNAL the Council decided it is no longer necessary to send copies of these minutes to each councilor.

The Council adjourned until Wednesday morning following the meeting of the House of Delegates.

THOMAS A. HENDRICKS,
Executive Secretary.

Second Meeting

(French Lick Session, September, 1933)

The second meeting of the Council convened at 10:00 a. m., Wednesday, September 27, in a private dining room of the French Lick Springs Hotel, immediately upon adjournment of

the final meeting of the House of Delegates. The minutes of the previous meeting were not read. The roll call showed the following members present:

COUNCILORS

1st District.....John H. Hare, Evansville
2nd District.....H. C. Wadsworth, Washington
5th District.....O. O. Alexander, Terre Haute
7th District.....L. A. Ensminger, Indianapolis
8th District.....M. A. Austin, Anderson
9th District.....F. T. Romberger, Lafayette
12th District.....E. M. VanBuskirk, Fort Wayne
13th District.....W. B. Christophel, Mishawaka

EXECUTIVE COMMITTEE

W. H. Kennedy, Indianapolis, Chairman
T. A. Hendricks, Executive Secretary

As the resolution in regard to setting the date for the state meeting later in the year was acted upon favorably by the House of Delegates the Council suggested that the Executive Committee consult with the proper officials of the Indianapolis Medical Society, hosts for the 1934 meeting, in regard to the setting of this date.

Dr. Alexander, Chairman of the Council, explained that as the complete financial reports for 1933, along with the report of the Budget Committee, should be reviewed by the Council at the midwinter meeting, this meeting would be held sometime around the tenth of January in the new year rather than as in the past during December of the present year.

There being no further business the Council was adjourned.

THOMAS A. HENDRICKS,
Executive Secretary.

HOUSE OF DELEGATES

First Meeting

The first meeting of the House of Delegates convened at four fifteen, Monday afternoon, September 25, 1933, in the convention hall of the French Lick Springs Hotel, French Lick, the president, Dr. Joseph H. Weinstein of Terre Haute, in the chair.

On motion of Dr. H. G. Hamer, seconded by Dr. J. W. Shafer, the attendance slips distributed at the door were accepted as the roll call of the House. Dr. George Miller, chairman of the Credentials Committee, asked that the slips be handed to him as the delegates left, stating that he would make a report at the Friday morning meeting of the House.

THE CHAIRMAN: Twenty delegates are sufficient to form a quorum. There is no question that we have a quorum here; the House of Delegates, therefore, is declared open and ready for the transaction of business.

I wish to call your attention to the fact that the By-Laws may be amended at any annual session by a majority vote of all delegates present at that session after the amendment has laid on the table for one day. Also, the House of Delegates may amend any article of the Constitution by a two-thirds vote of all delegates present at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session and that it shall have been published twice during the year in THE JOURNAL of the Association.

The minutes of the last meeting of the House of Delegates were published in THE JOURNAL of October, 1932. If there is no objection we will take the printing of the minutes in that JOURNAL as having been read. (Passed by unanimous consent.)

THE CHAIRMAN: I took it upon myself to ask the delegates of the American Medical Association to meet with us here today as ex-officio members with the privilege of the floor but without the privilege of voting. I did that with the thought in mind that they can go to the meeting of the American Medical Association with much better preparation of what we in the Indiana State Medical Association want. I would like a motion in the House that they be given the privilege of the floor.

DR. WILLIAM R. DAVIDSON: I will make such a motion. (Motion seconded by Dr. F. W. Black, and carried.)

THE CHAIRMAN: So ordered. Dr. Crockett as your president last year started an innovation which appeals to me as being most appropriate to this kind of a session. It gives the opportunity for our president-elect to talk to us and give us some of his ideas of what he may have in mind for the ensuing year. We will ask Dr. Padgett as our president-elect to talk to us for a few moments.

ADDRESS OF DR. E. E. PADGETT

Our plans for 1934, like the plans of any other growing concern, must be based on the results of things that have gone before. Indiana medicine, and by this term I mean organized medicine in Indiana, has had years of growth; some good, some not so good. Still, all in all, our progress has been upward with a steady incentive which embraces two definite aims. First, the care of the sick both by prevention and cure, and second, the improvement in our own ranks; in other words, to furnish the people better medical services by furnishing them better doctors. This noble principle, set out so forcibly in our code of ethics, has always been adhered to, and will continue to be adhered to, come what may.

As you all know, the foundation of medical progress in Indiana has been well laid by our forefathers who looked to our interests in the matter of legislation, when the right kind of legislation was needed. Their names are legion with us, and may their works never be allowed to fade from our sight. By their efforts Indiana has taken and maintained her place in the front ranks of organized medicine. Not only are they our leaders in organization, but many of them our teachers in the actual acquirement of our medical education. We honor them, and hope to carry on in the spirit in which they taught us. That their works have not been in vain is abundantly proven by the things that have been met and conquered in the past few years by the men at the head of our medical society affairs. We have only to look over the records of the past two years at the work of these men, and we can be sure that were our predecessors here, they would be happy in the feeling that they have wrought well.

I do not believe that any time in the history of organized medicine has been more filled with important work than has the past two years. So thick and fast have come important matters that our headquarters office has been swamped in work. Never in the history of our organization has this work been half so heavy, or so well handled. When you realize that the work of this office was well near doubled by taking over THE JOURNAL, and more than trebled by new things that have come up for consideration and settlement, you may begin to realize the work done, and to appreciate the services rendered by your own Tommy Hendricks and his able assistants.

First there burst on our horizon the report of the Committee on the Costs of Medical Care, with its preconceived conclusions in favor of socialization of medicine. Never before has a matter of graver import faced the medical profession. Never before has an organization attacked a job with more vigor than did organized medicine attack this vulture of socialization, and never before has a cleaner victory been scored. So successful was this fight, that this report may now be placed on the shelf with the Wickersham report and allowed to drift with it into oblivion. In this fight Indiana added a star to her crown, and your present president rendered himself a near immortal.

It has been said by men high in official circles in this country that by the defeat of the preconceived plan, the medical profession has saved this country from socialism.

There is also that other situation of almost like importance, namely, hospital and medical treatment for all veterans regardless of whether their sickness or disability was in any way connected with their military service—a situation wrought with dire possibilities, a situation in which the politician found himself extremely busy, having one hand in the pocket of every taxpayer in the land, and the other on the throat of organized medicine. Of this fight you now all know the outcome. What you may not know is the fact that in the accomplishment of this result, no names in the nation stand higher than those of Crockett and Weinstein.

These two great subjects are now in a state of rest, and whether they will continue to rest, is a question for the future. The probability is that the latter will not. Even now aspirants to office with a view to getting votes, are traveling up

and down this land, criticizing the move, and proposing to repeal this legislation. In this move, gentlemen, it behooves you and me and all of us to recall that remark of another man high in the counsels of the National Government who said, "Organized medicine does not realize its strength." Watch your step and see that no man goes as your representative to Washington who plans to lend his aid to the rejuvenation of this, the greatest of all rackets ever faced by organized medicine.

Other questions of importance have arisen which are now receiving our attention, and will continue to require our attention through 1934 and for years to come.

A word as to legislative action in 1933. There seldom has been a meeting of the state legislature which did so much that has a direct effect on the medical profession. Most comments on this fact lead one to believe that most of this legislation will be to the benefit of the individual doctor, and in turn to organized medicine. Dr. Morris Fishbein, in commenting on legislation in Indiana, said, "You men should surely be satisfied. You got everything you wanted and nothing you did not want."

Out of this legislation came some of our most immediate problems.

1. New set-up of the State Board of Health. This places public health where it should be and where we have long wanted it, i.e., in the hands of the local county society. Each county, in fact each man is responsible for public health in his own county. This is an all important point, and one that will require plenty of time and effort to carry out. The opportunity is yours, and your state association is not expecting you to fail.

2. Care of the indigent. This has been our greatest problem since the beginning of the depression. Much has been done to furnish these unfortunate people relief, but much remains to be done. We have only begun to fight.

Many county societies have worked out plans as societies which have been very satisfactory; others not so good. The duty of the physician remains to take care of the sick. This he has done and will continue to do. However, all recognize that he should be reimbursed. The state association has planned and helped plan for this work to be carried out by county societies—to discourage all forms of contract practice by individual physicians, and to take care of these people at a rate that can be paid, keeping in mind always the relation of physician and patient.

3. Legislative action concerning care of indigent patients in home counties. Much complaint has arisen about the large number of patients committed to the Riley Hospital. To correct this the last legislature made it possible for these cases to be treated in their home county, and some court order to take care of payment as now applies to patients sent to Riley. Again this puts it up to the local doctors to take care of your own cases in your own community. This already has been done in some counties, and it is our hope that it will be extended to others in the coming year.

Activities of Laymen and Lay Societies in Practice of Medicine

The depression has again given rise to a viper in the person of the layman or the lay society who casts envious eyes in the direction of medicine. He may appear in the guise of a benefactor both to the public and the profession. What he proposes is simply a scheme whereby he will chisel in and take for his own use a rake-off from the fee that should go to the doctor, and that the patient thinks does go to the physician. There is no place for a middleman in medicine. He occupies the same situation in the scheme that the ambulance-chasing agent occupies in the legal profession. It is to be hoped that no man in our ranks will be deluded into falling for this scheme. If men do embrace this opportunity to harvest a few ready dollars at the expense of his more honest colleagues, the remedy is simple. He is simply employing a solicitor which is specifically forbidden by our code of ethics, and it is time for him to be dropped from the roster of his county society.

Group Hospitalization

Another feature that has crept into our councils as a result of the depression is the so-called group hospitalization. This in itself is bad enough, but the fact that once the hospital payment plan is adopted as group insurance, or under any other name, it is only a step until the same forces will seek to employ doctors on the same basis, will drive down fees, and will rob the practice of the personal touch on which all our practice so much depends. This has been defeated in Indiana up to the present time; not so in many other states. It probably will return to us in some other guise and it is well to be prepared to meet it.

Tax Supported Hospitals

That these hospitals are abused is beyond doubt. I am thoroughly convinced, and have been for a long time, that no teaching hospital should have any pay beds. Probably to eradicate this entirely is impossible, but for us as county societies to discourage the abuse is quite possible and should be done.

Our Postgraduate Work

This part of our work has assumed important proportions in the past two years. From all indications the doctors of the state are for it, and the methods employed appear to have their hearty support. It shall be the plan in the coming year to improve it where improvement is possible.

Relation to Organizations Dealing in Health Matters

It behooves us to cultivate a friendship, and to work in closer union with these agencies, i.e., Boards of Public Health, State Tuberculosis Association, State Nurses' Association, State Dental Society, State Pharmaceutical Association, and others.

These associations are all closely related in their work to us. They are willing and anxious to cooperate with us, and such cooperation should be encouraged.

These, gentlemen, are a few of the problems which we can now see for 1934. No doubt in the kaleidoscopic changes that are coming so rapidly many others will arise. It will be our duty and it is our intention to meet them, keeping always in mind the place of the physician in our economic development and above all the welfare of the patient, which is again based on his inherent right to call the physician of his choice. Never before have our opportunities to give the physician his rightful place in society been so great. Never before have our responsibilities been so great. And, never before has the medical profession been so well organized and hence so well prepared to take care of both opportunity and responsibility.

* * *

THE CHAIRMAN: In accordance with Chapter IX, Section 1, of the By-Laws of the Association, reference committees shall be appointed by the president immediately after the organization of the House of Delegates, these committees to serve during the session at which they are appointed. These reference committees should not be confused with the all-year round standing committees. To these committees shall be referred all reports, resolutions and measures presented to the House of Delegates, except such matters as properly come before the Council, and the recommendations of these committees shall be submitted at the next meeting of the House of Delegates for acceptance in the original or modified form, or for rejection. The next meeting of the House of Delegates will be held Wednesday morning at 7 o'clock. Each committee consists of five members and the first member named will be the chairman. The reference committee as appointed will be as follows and, as the names are read, so that we will know you are here and will serve, you will please stand.

(Announcement made that the president and the secretary had divided the Reference Committee on Public Policy and Legislation as there was so much work to come before this committee, making a Committee on Legislation and a Committee on Public Policy.)

Committee on Reports of Officers:

John Carmack, Indianapolis, *Chairman*.....Marion
W. E. Jenkinson, Mt. Vernon.....Posey
Earl VanReed, Lafayette.....Tippecanoe
T. Z. Ball, Crawfordsville.....Montgomery
J. D. Sturdevant, Noblesville.....Hamilton

Sections and Section Work:

V. L. Turley, Fowler, *Chairman*.....Benton
Boyd Burkhardt, Tipton.....Tipton
C. F. Fletcher, Sunman.....Dearborn-Ohio
B. J. Larkin, Indianapolis.....Marion
R. L. Compton, Osgood.....Ripley

Rules and Order of Business:

George DeTar, Winslow, *Chairman*.....Pike
C. E. Thomas, Leesburg.....Kosciusko
V. E. Wiseman, Greencastle.....Putnam
W. E. Amy, Corydon.....Harrison

Medical Education and Hospitals:

A. C. Yoder, Goshen, *Chairman*.....Elkhart
D. W. Schafer, Fort Wayne.....Allen
M. C. McKain, Columbus.....Bartholomew
W. D. Little, Indianapolis.....Marion
E. L. Schaible, Gary.....Lake

Legislation:

O. G. Brubaker, Wabash, *Chairman*.....Wabash
A. W. Cavins, Terre Haute.....Vigo
P. A. Garber, South Whitley.....Whitley
W. F. Kelly, Indianapolis.....Marion
M. L. McClain, Scottsburg.....Scott

Public Policy:

J. W. Shafer, Lafayette, *Chairman*.....Tippecanoe
H. G. Hamer, Indianapolis.....Marion
P. J. Birmingham, South Bend.....St. Joseph
Claude Dollens, Oolitic.....Lawrence
R. W. Bruner, Jeffersonville.....Clark

Publicity:

Charles N. Combs, Terre Haute, *Chairman*.....Vigo
I. N. Trent, Muncie.....Delaware-Blackford
C. M. Clark, Oakland City.....Gibson
V. V. Cameron, Marion.....Grant
Jesse E. Ferrell, Fortville.....Hancock

Hygiene and Public Health:

F. W. Black, Ligonier, *Chairman*.....Noble
E. O. Asher, Indianapolis.....Marion
C. J. Adams, Kokomo.....Howard
A. S. Newell, Converse.....Miami
C. J. Clark, Indianapolis.....Marion

Amendments to Constitution and By-Laws:

W. N. Wishard, Indianapolis, *Chairman*.....Marion
F. S. Crockett, Lafayette.....Tippecanoe
B. G. Keeney, Shelbyville.....Shelby
V. E. Harmon, South Bend.....St. Joseph
H. M. Baker, Evansville.....Vanderburgh

Credentials:

S. P. Hoffman, Fort Wayne, *Chairman*.....Allen
H. D. Caylor, Bluffton.....Wells
H. W. Garton, Fort Wayne.....Allen
George R. Daniels, Marion.....Grant
John S. Ketcham, Rossville.....Clinton

Miscellaneous Business:

Harry W. Helmen, South Bend, *Chairman*.....St. Joseph
O. R. Spigler, Terre Haute.....Vigo
J. H. Crowder, Sullivan.....Sullivan
W. A. Thompson, Liberty.....Wayne-Union
C. F. Hope, Ellettsville.....Monroe

These committees should organize immediately after adjournment of the House of Delegates and make arrangements for meeting either tonight or tomorrow.

Upon motion of Dr. W. R. Davidson, duly seconded, and carried, the following reports were accepted as printed in the Handbook and referred to the proper committees, each chairman being given five minutes, if desired, to make any additions to the printed report.

REPORTS OF OFFICERS

Executive Secretary.
Treasurer.
Chairman of Council.
Executive Committee.
Editor of THE JOURNAL.
Delegates to the A. M. A.

DR. O. O. ALEXANDER: I have nothing to add to the report as printed in the Handbook on the major activities of the Council during the year. However, the Council held its regular meeting at noon today at which time every councilor was present. At this time Dr. E. M. Shanklin was re-elected as editor of the THE JOURNAL as beginning January 1, 1934, up to January 1, 1935, and Dr. L. P. Harshman of Fort Wayne was elected to fill the vacancy on the Editorial Board following the end of Dr. Comb's term of office. Dr. Combs was elected last year for one year. Dr. Harshman will serve for five years. There was only one other thing of import at the noon meeting of the Council and that is a resolution in reference to a change in the time of the annual meeting which I will present later.

Referred to Reference Committee on Reports of Officers.

REPORTS OF STANDING AND SPECIAL COMMITTEES

Committee on Credentials

Referred to Reference Committee on Credentials.

Committee on Legislation and Public Policy
Special Committee on Registration

DR. EARL VAN REED: One point should be added to this report after conclusions. The registration fee should be available for use by the board. Any funds remaining at the end of the year should not be turned over to the general fund; they should go to the board.

Special Committee on Health Insurance
Special Committee on Medical Care of Indigent

Referred to Reference Committee on Legislation.

Committee on Civic and Industrial Relations
Committee on Veterans' Hospitalization
Special Committee on Public Relations

Referred to Reference Committee on Public Policy.

BUREAU OF PUBLICITY

DR. W. N. WISHARD: There is very little to add to the fourteen pages of printed matter of the report of the Bureau of Publicity. I do ask your indulgence in commenting on one recommendation which has been embodied in practically every report we have filed. Our recommendations on this matter have been approved from year to year by the House of Delegates and bear the force of law in that respect. We have had a few inquiries as to whether it is all right and ethical for individual physicians who are appointed by their county societies to prepare releases for the public to have the announcer introduce them as "Dr. John Smith, a well-known specialist in something or other," or "Dr. John Smith, one of our prominent physicians." Now this has become a very irritating thing to the Bureau of Publicity. It ought not be. There should be no releases given over the radio where the name of the physician is given. We have excuses given to the effect that the people will understand it better or pay more attention if they know that their family physician is giving that release. If it is stated by the announcer that this release is authorized by the collective group of an organized county, it certainly ought to carry more weight than if it carries the name of John Smith or anybody else. I emphasize this because you hamper the work if you do this. Fortunately, there have been but few offenders. I appeal to you to hold up our hands. We are doing honest work. We are spending not only hours but days at work on the carefully outlined program of the Bureau of Publicity which is covered by this printed report.

Report of Committee on State Fair

House of Delegates, Indiana State Medical Association:

The exhibits of the Indiana State Medical Association and the American Medical Association were based on the titles, "Patent Medicine and Quackery" and "The Dangers of Self Diagnosis." This material was furnished by the American Medical Association and consisted of several mechanical models, about forty posters and a complete set of pamphlets dealing with the various forms of quackery. Material dealing with the health magazine, Hygeia, was also shown.

The biggest attraction of the exhibit, however, was the self-recording blood pressure machine. This was furnished by the Taylor Instrument Company. Over 2,500 pressures were taken during the week, from a varied assortment of visitors and some interesting figures were obtained. When excessive pressures were noted the visitor's name and address and his physician's name and address were taken and the visitor was advised to see his doctor, care being taken, however, not to cause alarm over the condition found.

Some interesting statistics were obtained: The average State Fair visitor was 41.2 years of age, weighed 153.9 pounds and had an average blood pressure of 145.9 systolic and 91.2 diastolic. These figures represent a composite picture of the 2,500 blood pressures taken. The highest systolic blood pressure was 320; lowest systolic blood pressure was 90. The highest diastolic blood pressure was 175; the lowest diastolic pressure was 50. The oldest person whose blood pressure was taken was eighty-five years of age; the youngest was four years. The largest person weighed 275 pounds, the smallest weighed forty pounds.

Dr. R. L. Sensenich of South Bend, Dr. J. E. Ferrell of Fortville, Dr. Thurman B. Rice and Dr. G. W. Batman of Indianapolis were in the booth on their respective days and gave valuable assistance and information.

About 25,000 people saw the exhibit and we feel fairly well pleased with the first year's undertaking.

Expenses were for the following items:

Doctors' expenses	$40.00
Three assistants	90.00
Express	9.78
Signs	5.00
	$144.78

Respectfully submitted,

R. A. Sage, Indianapolis, Chairman.
J. E. Ferrell, Fortville.
R. L. Sensenich, South Bend.
H. P. Graessle, Seymour.
G. H. Wisener, Richmond.
Thurman B. Rice, Indianapolis.
Gordon W. Batman, Indianapolis.

Referred to Reference Committee on Publicity.

Committee on Medical Education and Hospitals
Committee on Postgraduate Study
Special Committee on Business Instructional Course

Referred to Reference Committee on Medical Education and Hospitals.

Committee on Scientific Work

Referred to Reference Committee on Sections and Section Work.

Committee on Necrology
Committee on Convention Arrangements
Committee on Secretaries' Conference

Referred to Reference Committee on Miscellaneous Business.

Committee on Diphtheria
Special Committee on Study of High School Athletics
Special Committee on Lye Burns in Children
Special Committee on Study of Puerperal Mortality

Referred to Reference Committee on Hygiene and Public Health.

Special Committee on Medical Defense Fund

Dr. S. P. Hoffman: Inasmuch as this report will have to be voted on by the House and contains recommendations, I should like the committee to which it is referred to review it very carefully and I also would like for the members to look it over. Each member should acquaint himself with the report.

Referred to Reference Committee on Amendments to Constitution and By-Laws.

(At this time Dr. R. L. Sensenich of South Bend, delegate to the American Medical Association, gave an informal report based on the official statement that appeared in the July, 1933, Journal.)

The Chairman: Dr. Crockett will now talk to you on the foremost question in our minds, that is, in just what position do we stand in the Federal Emergency Relief Act?

Dr. F. S. Crockett: In the past the township trustee has been the big factor in indigent sick work. The recent law now places him at the foot of the whole organization. At the top is the Governor, then his Committee on Indigent Relief, Fred Hoke; then the district chairmen are distributed over the state who are members of that committee, and under the district chairmen are the trustees. The law even provided that the trustee should be removed if he did not function in the way the committee thought he should. You know in the past the township trustee has hired someone to take care of the perpetual indigent. In my own township there were sixty-five or seventy-five families on the township. They were taken care of by the township. They were poor and intended to remain poor. They had no choice in their physician and it made no matter to them. During this depression the indigent have increased from one-fifth to one-third of the community population in many places. That means that many of our families that we have taken care of for years have now been compelled to seek the services of the physician hired by the trustee, if this system is still in existence. That system was in effect in my township. Situation grew until we had out of a population of some 25,000 people, 1,400 families that became a community problem . . . It seemed that the community and the doctors had some sort of an interest which should be expressed. In taking up the work by the committee appointed, we found that the problem of taxes was a very important thing. It became very apparent that to change our method from the township to that of all the doctors in the community who desired to work being called would increase the cost materially. With the idea of increased taxes in mind we decided not to see the trustee but came down to see the Executive Committee. . . .

Plan includes general principles: First, temporary indigent who in past had family physician should be allowed to receive the services of that physician; second, physician who renders service should be paid on some sort of fee basis to meet that situation; third, it also seemed wise to us that if this plan could be put in order that the temporarily indigent family would find it easier to resume the financial relationship toward his family physician than if he were compelled to seek relief from some doctor whether he liked him or not.

. . . Mr. Book said this was a proper charge to relief expense. In other words the taxpayers under this plan instead of having to pay a greater tax would get tax relief to that extent. Mr. Book was encouraged and well received in his work at Washington. The booklet from Washington embodies all the points put forth by the Executive Committee:

(1) The patient should be permitted to select his own physician.

(2) There should be some fee basis, less than the usual fee. So far we have gained everything that we could ask for so far as principles are concerned. In the application of those principles certain things have come up which are not altogether to our liking. Certain contractual relationships have been preserved on the plea that the particular work given in that locality was adequate and of a good quality and to change it would be to increase the cost without any benefit to the indigent who, after all, are to be considered first.

Any of you who wish to adopt this plan in your own community may do so. The general principles may be modified to suit your local situations. The chairman of the indigent relief work in your district will deal with your county society or that group of your county society who wish to do this work.

Certain details would have to be worked out in eaeh community. The whole set-up is in the hands of Mr. Book and the Exeeutive Committee. Now we have aecomplished something and it is a matter now of realizing on that aceomplishment. Just a few weeks ago, praetieally a few days ago, Mr. Book released his instruetions to his ehairmen to deal with the county soeieties on the basis outlined and then held them up for a few days beeause Washington had issued instruetions and he wished to study them before the final release. We have not worked out anything definitely in Tippeeanoe County.

At the state secretaries' meeting in Chieago last Friday eertain phases of this eame up for discussion whieh I think Mr. Hendricks should be asked to tell you about.

THE CHAIRMAN: At Dr. Crockett's suggestion we will ask Mr. Hendricks to tell us about the Chieago meeting.

MR. T. A. HENDRICKS: Although it was not on the offieial program for the annual sceretaries' eonference which the state secretaries hold onee a year at Chicago, it was very evident after the first few papers that everyone in the group was much more interested in this question than in any other question on the program. As a result a speeial time was set aside for diseussion of this subject.

To almost every man there this work was entirely new. Indiana found itself in a very fortunate position beeause of the work it had been doing for the past three years. If you reeall, Governor Leslie had a medieal service eommittee appointed which made a survey of medieal services rendered the indigent sick in Indiana. Questionnaires were sent to the 1,100 odd township trustees. That survey brought out some valuable information and we had a foundation on which to build when contact was made more reeently with Mr. Hoke and Mr. Book. With all this background, at times it looked as if the situation had reaehed sueh a point that we would have to break off all negotiations entirely, and it has only been by the most patient and painstaking work of your Exeeutive Committee and a spirit of eooperation on the part of Mr. Hoke and Mr. Book that a plan was finally worked out.

It developed at Chicago that only five states were in position to work immediately along the lines set forth by the Federal Emergeney Relief Act regulations No. 7—New York, New Jersey, West Virginia, Kentueky and Indiana. The fact that the Indiana profession had drawn up an agreement with the State Relief Director in a simple form made it very evident to the other state society seeretaries that if they had a copy of the Indiana plan it would aid them in formulating a plan in their own states. Only yesterday the Exeeutive Committee of the Illinois State Medieal Assoeiation and today the Minnesota Association met to consider plans for this serviee. Both of these groups asked for eopies of the Indiana plan. Many state secretaries did not even know who their relief direetors were. So, although the Exeeutive Committee has called on many of you to help out in formulating this plan and perhaps it looked as if your time had been spent without any marked results, I believe that it will be worth all the time and energy put into it.

UNFINISHED BUSINESS

THE CHAIRMAN: Under unfinished business we have the amendment to the Constitution and change in the By-Laws creating a speaker and a viee-speaker of the House of Delegates. This was introdueed two years ago, was up for vote last year and was laid over on motion of the House until this year. It is now up for eonsideration.

(At the request of the delegates the seeretary read the proposed amendment whieh follows.)

"*Be it Resolved*, That Artiele IX of the Constitution of the Indiana State Medical Assoeiation be amended to read as follows:

"The offieers of this Assoeiation shall be a President, a President-eleet, an Exeeutive Seeretary, a Treasurer, a Speaker and a Vice-speaker of the House of Delegates, and Thirteen Counellors."

"*Be it Resolved*, That Seetion 1 of Chapter VI of the By-Laws of this Association be amended by striking out the following words: 'and of the House of Delegates,' in the second and third lines of said section; and that Chapter VI be further amended by adding an additional section thereto following section 4 and preeeding section 5, whieh said seetion shall be designated as section 4-a, and shall read as follows:

The Speaker of the House of Delegates shall preside at all meetings of the House of Delegates and shall perform sueh duties as presiding officer as custom and parliamentary usages require. He shall have the right to vote only when his vote shall be neeessary to deeide.

The Viee-Speaker of the House of Delegates shall perform the duties of the Speaker in the latter's absenee or at his request.

In case of death, resignation or removal of the Speaker the Vice-Speaker shall suceeed him in office and offieiate during the unexpired part of the term to whieh the Speaker was eleeted."

DR. W. F. KELLY: I move that this amendment to the Constitution and By-Laws be adopted.

DR. GEORGE DANIELS: I move that it be laid on the table. (Motion seeonded by Dr. A. C. Yoder, and carried.)

THE CHAIRMAN: We have another ehange in the Constitution and By-Laws whieh places the president-elect on the Executive Committee in place of the editor of THE JOURNAL, which is up for final vote now. The secretary will read the amendment.

"Amend Article V of the Constitution by omitting 'and the Editor of THE JOURNAL of this Assoeiation' and substituting therefor 'the President-eleet,' thus making this Article read: 'The House of Delegates shall be the legislative and business body of the Association and shall eonsist of (1) the Delegates elected by the component societies; (2) the Councilors; (3) the ex-Presidents of the Indiana State Medical Assoeiation; and (4) *ex officio*, the President, President-elect, the Executive Secretary and the Treasurer, without power to vote exeept in ease of a tie vote when the President shall cast the deciding vote.'

"Amend Artiele VI of the Constitution by omitting 'and the Editor of THE JOURNAL' and substituting therefor 'and the President-elect,' thus making this Article read: 'The Council shall eonsist of (1) the Councilors; and (2) *ex officio*, the President, President-elect, Exeeutive Seeretary and Treasurer.' The remainder of this Article to be unchanged.

"Amend Chapter II, Seetion 4, of the By-Laws by omitting 'the Editor of THE JOURNAL' and substituting therefor 'The Editorial Board,' thus making this seetion read: 'All papers read before the Association or any of the sections shall beeome its property and shall not be published in any but the offieial publieations of this Assoeiation, except by eons nt of the offieers and the Editorial Board.' The remainder of the section to be unchanged.

"Amend Chapter VII, Seetion 13, of the By-Laws by omitting 'the Editor of THE JOURNAL' and substituting therefor 'the President-elect,' thus making this seetion read: 'The Council shall elect a eommittee of five members of the Association, three of whom in eonsequenee of their neeessarily intimate relationship with the affairs of the Assoeiation shall be the President, the President-eleet, and the ehairman of the Counеil, whieh shall be known as the Exeeutive Committee'."

DR. E. M. SHANKLIN: I move the adoption of the resolution as read. (Motion seconded by Dr. J. H. Hare, and carried.)

NEW BUSINESS

DR. W. F. KELLY: I have an amendment to Chapter VIII, Section 1, of the By-Laws. I will say in regard to this amendment that as you know, today we have a large number of committees. Now those committees are on subjects which perhaps could be grouped. Now that makes a good deal of work for the president in the appointment of his eommittees. It seems to me it would be better to have the work eondensed. Instead of having fifteen or twenty committees, this amendment will reduee the eommittees to twelve major eommittees. These eommittees ean be augmented by sub-eommittees. I

think in that way we will really get a larger number to take part in this work that comes under committees. I have the following resolution to offer to you:

Amendment to By-Laws, Chapter VIII, Section 1:

"To insert the following named committees after the words, 'A Committee on Budget':

A Committee on Public Relations.
A Committee on Secretaries' Conference.
A Committee on Credentials.
A Committee on Necrology.
A Committee on Journal Publication.

"Also to insert after the words 'Executive Committee' in line 11 the words, 'and Committee on Journal Publication,' and following the word 'Committee' and preceding the word 'the president' to insert the following: 'Either the president, or any committee with consent of the president, may appoint a subsidiary committee to assist a committee with its work'."

Referred to the Reference Committee on Constitution and By-Laws.

DR. O. O. ALEXANDER: I have a resolution to present. Just a word of explanation in reference to it. The Executive Committee and the Council have been requested repeatedly during the past two or three years to make some change in the date of the annual meeting. This request has come particularly from some members of the Association who belong to a special x-ray society. Owing to a conflict they are unable to attend either this meeting or the other meeting. In order to bring the matter to a crux the Council decided to present this resolution this evening:

"*Whereas*, The present date of meeting of the Indiana State Medical Association is in conflict with certain of our national special society meetings in which many of our members are interested, and

"*Whereas*, Many of our men who are members of these special societies have brought the matter before the Executive Committee and the Council on numerous occasions, and

"*Whereas*, In recent years almost universal complaint has been made on the part of our members in regard to the weather during the month of September, therefore

"*Be it Resolved*, That the Executive Committee be empowered to make such change in the date of our annual session as will avoid the aforementioned objections.

O. O. ALEXANDER,
Chairman of the Council."

Referred to the Reference Committee on Sections and Section Work.

The following resolution, introduced by Dr. C. J. Clark, was read by the executive secretary:

"*Whereas*, Insurance companies demand of their policyholders proof of death, and

"*Whereas*, They furnish forms to be executed by the attending physician which contains more information for the companies' use in mortality statistics than for proof of death, and

"*Whereas*, Physicians are asked to fill out these death claims during their office hours which by reason of their concentrating their work at this time are usually crowded, and

"*Whereas*, The physician often finds it difficult or impossible to collect for such services from the individual,

"*Be it Resolved*, That the Indiana State Medical Association approve and instruct its delegates to the American Medical Association to present a resolution before that body asking that a committee be appointed to meet with the National Underwriters to investigate the possibility of having insurance companies retain a fee for such service either by increase in premium charges or by withholding a sufficient sum from dividend disbursements to pay directly to the physician a satisfactory fixed fee for such service.

C. J. CLARK, M. D.,
Indianapolis, Ind."

Referred to the Reference Committee on Miscellaneous Business.

DR. JOHN H. HARE presented the following resolution:

"*Whereas*, The fund in the Medical Defense Fund has accumulated to a sufficient amount that the income thereon with conservative investment will produce a return of sufficient amount, and

"*Whereas*, Postgraduate courses are an established custom of the Indiana State Medical Association, and

"*Whereas*, These courses cannot be given under the present arrangement without charging physicians attending these courses a fee to cover expenses,

"*Therefore Be it Resolved*, That the Executive Committee be empowered to use the preceding year's income from this fund for the payment of expenses for two or more postgraduate courses the following year."

DR. HARE: With the thought contained in the resolution just presented, I present the following resolution:

"*Whereas*, The report of the special Committee on Medical Defense as printed in the September, 1933, JOURNAL recommended the study of medical defense with the thought of payment of indemnity or judgment, and

"*Whereas*, The assumption of indemnity or judgment liability would place the Association in the insurance business and under the supervision of the State Insurance Department, and

"*Whereas*, The assumption of indemnity or judgment liability would take away one of the strong points which discourages filing of suits against members by shyster lawyers or unscrupulous persons, and

"*Whereas*, The present plan of operation of the Medical Defense feature of the Association has been efficient and satisfactory for twenty-one years, and

"*Whereas*, The fund in the Medical Defense Fund has accumulated to an amount safely sufficient for all purposes under our present by-laws,

"*Therefore Be it Resolved*, That it is the sense of this association that no change be made in operation of the Medical Defense feature of the Indiana State Medical Association, and

"*Be it Further Resolved*, That the income from the invested funds of the Medical Defense Fund be made available for payment of expense for postgraduate work, and

"*Be it Further Resolved*, That Chapter XII, Section 4 of the By-Laws be changed by adding after the word 'Council' in the last line, the following words:

" 'Surplus funds shall be invested by the Treasurer in such securities as may be approved by the Executive Committee, but whatever income received from such invested funds shall be appropriated by the Executive Committee for expense of postgraduate meetings sponsored by the Indiana State Medical Association'."

THE CHAIRMAN: These resolutions will be referred to the Reference Committee on Constitution and By-Laws.

DR. B. G. KEENEY: This is not a resolution but for personal reasons it concerns me to know why the State Board of Medical Registration and Examination does not recognize the National Board.

DR. W. R. DAVIDSON: The attorney general of each administration for the last twelve years has shown that the medical law prohibits that. The first and second paragraphs of the Medical Practice Act say that "the Board shall examine or recognize by reciprocity from other states."

The attorney general has held that the National Board is a voluntary organization and has no legal status. This can be corrected only by an act of the legislature. One attorney general said that it was a board that was founded by one man and it has no legal standing. If the National Board would obtain a charter from Congress, our Board would promptly give recognition. Personally, I believe that the Board would probably be glad to do it, but under the law it cannot. All these states that do recognize it have had some special act passed by the legislature.

DR. W. F. KELLY: There was one thing brought to my attention a few days ago which I don't know whether the members of this organization really know about—that is that

Dr. Morgan of Indianapolis told me that he had to recognize death certificates signed by chiropractors, faith healers, etc. He said that the last Medical Practice Act of this state allowed that to be done. It allowed him no recourse.

DR. DAVIDSON: I directed a letter to the attorney general at the time that went in and received reply that at the time the 1927 law went into effect, it gave all these practitioners right to sign death certificates. I might also say that a number of the states have been writing to the Board, trying to make Indiana recognize the chiropractors, etc., by reciprocity, which is a privilege, not a right. These practitioners are all held to the minimum requirements, and in this ruling the Board has been upheld by the Supreme Court. They are required to have two years' preliminary medical training in college and four years in a professional school, just as all other applicants are required to have, regardless of school. We'll endorse them to other states, but we will not accept any of them, unless they can meet the minimum requirements. I will say this too, that there are some assistants in the attorney general's office this year that are giving the finest kind of assistance to the medical board. We never have had such cooperation as we are getting right this minute from the attorney general's office.

DR. KEENEY: Forty-two states in the United States recognize it, the Navy and Army recognize it, the American College of Physicians and the American College of Surgeons recognize it; it can't be so wrong. Wouldn't it be proper for us to counsel with the attorney general and change that "shall" to "may"? I think with these forty-two states recognizing it, it would be a compliment to us to do so also.

DR. DAVIDSON: I would be very glad to see the Board recognized, but it must be done under the semblance of law. Dr. Keeney is misinformed, however, about counsel with the attorney general endeavoring to have the word "shall" changed to "may"; it is not within his jurisdiction and will require action on part of the legislature in changing the statute. We need, and we need badly, the codification of the medical law . . . so many amendments that it is in a terrific hodgepodge, but if such a proposed change comes up, it will meet an organized effort to destroy the medical law in Indiana. In three or four more years we may be ready. I should dread to see a codification before the next legislature, under present conditions, for it would mean danger.

DR. KEENEY: I make a motion that a committee, of which Dr. Davidson shall be a member, be appointed and that an investigation of this be made and a resolution in regard to it be reported to the next meeting of the State Medical Association. Now, the state legislature doesn't meet until a year from next January. That will give us plenty of time. (Motion seconded by Dr. S. P. Hoffman, but lost.)

THE CHAIRMAN: I would like to make a suggestion to the House, and that is the real necessity of the codification of the Constitution and By-Laws. We have gone on for a number of years with a number of new resolutions and by-laws being passed. There are some mix-ups, some discrepancies. It just appeals to me as for the benefit of our secretary, for the benefit of our committees, and for the benefit of our incoming officers that it really is a necessity, and I would like to have a motion that we have the Constitution and By-Laws codified and printed.

DR. E. M. SHANKLIN: I move that that be done. (Motion seconded by Dr. W. F. Kelly, and carried.)

THE CHAIRMAN: If your reference committees will get together for just a moment to get ready for your real work, it will help.

Be sure and return your cards to Mr. Hendricks as that is the only way you will be counted present.

The first meeting of the House of Delegates adjourned to Wednesday morning, September 27, at seven o'clock.

SECOND MEETING

The second meeting of the House of Delegates, a breakfast meeting, was held at the French Lick Springs Hotel, French Lick, the president, Dr. Joseph H. Weinstein, presiding.

Meeting called to order at 8:00 a. m.

Dr. George D. Miller, chairman of the Credentials Committee, called the roll, the attendance slips showing the following members present:

County	*Delegates*
Allen	H. W. Garton, Fort Wayne
	S. P. Hoffmann, Fort Wayne
	D. W. Schafer, Fort Wayne
Bartholomew	Maurice C. McKain, Columbus
Cass	George D. Miller, Logansport
Clay	Fred C. Dilley, Brazil
Clinton	John S. Ketcham, Rossville
Daviess-Martin	S. L. McPherson, Washington
DeKalb	C. P. Fox, Garrett
Delaware-Blackford	I. N. Trent, Muncie
Elkhart	A. C. Yoder, Goshen
Fulton	A. E. Stinson, Rochester
Gibson	Carl M. Clark, Oakland City
Grant	V. V. Cameron, Marion
Greene	King L. Hull, Bloomfield
Hamilton	J. D. Sturdevant, Noblesville
Hancock	J. E. Ferrell, Fortville
Harrison	William E. Amy, Corydon
Henry	Walter M. Stout, Newcastle
Howard	Charles J. Adams, Kokomo
Huntington	J. B. Eviston, Huntington
Kosciusko	C. E. Thomas, Leesburg
Lake	E. L. Schaible, Gary
	G. L. Verplank, Gary
	J. M. White, Gary
Lawrence	Claude Dollens, Oolitic
Madison	O. A. Kopp, Anderson
Marion	E. O. Asher, New Augusta
	John W. Carmack, Indianapolis
	C. J. Clark, Indianapolis
	H. G. Hamer, Indianapolis
	Walter F. Kelly, Indianapolis
	Harry K. Langdon, Indianapolis
	Bernard J. Larkin, Indianapolis
	W. D. Little, Indianapolis
	Herman G. Morgan, Indianapolis
Monroe	C. F. Hope, Ellettsville
Montgomery	T. Z. Ball, Crawfordsville
Morgan	Edward M. Pitkin, Martinsville
Noble	F. W. Black, Ligonier
Orange	George Dillinger, French Lick
Parke-Vermillion	S. C. Darroch, Cayuga
Pike	George B. DeTar, Winslow
Posey	W. E. Jenkinson, Mt. Vernon
Putnam	V. Earle Wiseman, Greencastle
Ripley	R. L. Compton, Osgood
St. Joseph	P. J. Birmingham, South Bend
	V. E. Harmon, South Bend
	Harry W. Helmen, South Bend
Scott	M. L. McClain, Scottsburg
Shelby	B. G. Keeney, Shelbyville
Sullivan	J. H. Crowder, Sullivan
Tippecanoe	J. W. Shafer, Lafayette
	Earl VanReed, Lafayette
Vanderburgh	Herman M. Baker, Evansville
	A. M. Hayden, Evansville
Vigo	J. R. Gillum, Terre Haute
	O. R. Spigler, Terre Haute
Wabash	O. G. Brubaker, North Manchester
Wayne-Union	W. A. Thompson, Liberty
Wells	Harold D. Caylor, Bluffton
Whitley	Paul A. Garber, South Whitley

COUNCILORS

2nd District	H. C. Wadsworth, Washington
3rd District	H. C. Ragsdale, Bedford
4th District	H. P. Graessle, Seymour
5th District	O. O. Alexander, Terre Haute
6th District	Samuel Kennedy, Shelbyville
7th District	L. A. Ensminger, Indianapolis
8th District	M. A. Austin, Anderson
9th District	Floyd T. Romberger, Lafayette
10th District	E. M. Shanklin, Hammond
11th District	E. O. Harrold, Marion
12th District	E. M. VanBuskirk, Fort Wayne
13th District	W. B. Christophel, Mishawaka

PAST PRESIDENTS

J. C. Sexton, Rushville
W. H. Stemm, North Vernon
W. R. Davidson, Evansville
Charles N. Combs, Terre Haute
F. W. Cregor, Indianapolis
G. R. Daniels, Marion
A. C. McDonald, Warsaw
F. S. Croekett, Lafayette

OFFICERS

J. H. Weinstein, Terre Haute, President
E. E. Padgett, Indianapolis, President-Elect
A. F. Weyerbacher, Indianapolis, Treasurer
T. A. Hendricks, Indianapolis, Executive Secretary

THE CHAIRMAN: The chairman of the Credentials Committee having called the roll and a quorum being present, I hereby declare the House open for the order of business. The first order of business is the election of a president-elect.

ELECTION OF OFFICERS

PRESIDENT-ELECT

Dr. H. W. Helman nominated Dr. R. L. Sensenich of South Bend; nomination seconded by Dr. F. T. Romberger.

Dr. F. W. Black nominated Dr. Walter F. Carver of Albion; nomination seconded by Dr. George D. Miller.

Dr. B. G. Keeney nominated Dr. Walter McFadden of Shelbyville; nomination seconded by Dr. J. E. Ferrell.

Dr. George Dillinger nominated Dr. Walter J. Leach of New Albany; nomination seconded by Dr. Claude Dollens.

Moved by Dr. E. M. VanBuskirk that the nominations be closed and that the House proceed to ballot; motion seconded unanimously.

The chairman appointed Dr. L. A. Ensminger, Dr. O. R. Spigler and Dr. W. B. Christophel tellers.

Dr. Walter J. Leach was elected president-elect on the third ballot.

THE CHAIRMAN: Dr. Leach having received the majority of the votes, I hereby declare him elected president for the year 1935. I appoint Dr. Dillinger and Dr. Ragsdale to wait on Dr. Leach to notify him.

TREASURER

Dr. H. G. Hamer nominated Dr. A. F. Weyerbacher to succeed himself; nomination seconded by Dr. B. G. Keeney. Motion made by Dr. E. M. VanBuskirk that the nominations be closed and that the secretary cast the ballot for the treasurer to succeed himself; motion seconded and carried, and ballot cast by the executive secretary.

The Chairman introduced Dr. Leach, the president-elect for 1935.

DR. W. J. LEACH: Gentlemen: I don't know how to express my gratitude for the honor you have conferred upon me. I want to say to you this—my will will be to do the right thing and I will expect a whole lot of help from the rest of you, hoping we will get through all right.

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Dr. Earl VanReed nominated Dr. F. S. Crockett of Lafayette to succeed himself.

Dr. E. M. VanBuskirk nominated Dr. Don F. Cameron of Fort Wayne to succeed himself.

Dr. F. T. Romberger moved that the nominations be closed; motion seconded and carried. Dr. Van Buskirk moved that a viva voce vote on both nominees be taken at one time; motion seconded and carried.

Dr. F. S. Crockett and Dr. Don F. Cameron were elected for a period of two years to succeed themselves.

ALTERNATES TO THE AMERICAN MEDICAL ASSOCIATION

Dr. F. W. Black nominated Dr. W. F. Carver of Albion to succeed himself as alternate delegate; seconded. Dr. H. C. Wadsworth nominated Dr. G. D. Scott of Sullivan to succeed himself as alternate delegate; seconded. Moved by Dr. E. M. VanBuskirk that the nominations close and the unanimous ballot of the House be cast for Dr. Carver and Dr. Scott; motion seconded and carried. Ballot cast by the executive secretary.

At this time the Chairman introduced Dr. Walter L. Bierring of Des Moines, Iowa, president-elect of the American Medical Association and guest of honor of the convention.

DR. W. L. BIERRING: It is a great pleasure to be here. This is my first visit to French Lick. I am very much impressed with your selecting such a beautiful place for your convention. I can only say that the future of the American Medical Association depends upon the cooperation of constituent societies like your society. It is only by this complete integration with societies like your society that the American Medical Association can accomplish anything. It is only by this unity of action that we will be able to go forward. Every day there are associations springing up, more or less separate in their interest, and it is that which we should avoid. We have one common ideal and that is the preservation of our mother society, and that is what I think we do so much in these state organizations. It is a great pleasure to be here and I thank you for this reception.

ELECTION OF COUNCILORS

Election of the following councilors was confirmed:

Second District.....H. C. Wadsworth, Washington
Fifth District.....O. O. Alexander, Terre Haute
Eleventh District.....George D. Miller, Logansport

Dr. I. N. Trent reported that the Eighth District had held no meeting recently but it would do so soon at which time the councilor for the next three years for that district would be elected. This action was approved by the House.

SELECTION OF CITY FOR 1934 MEETING

Dr. W. F. Kelly, on behalf of the Indianapolis (Marion County) Medical Society, invited the Association to meet next year in Indianapolis. As no other invitations were extended, on motion of Dr. George Miller, duly seconded, the chair declared the meeting place for next year to be Indianapolis.

REPORTS OF REFERENCE COMMITTEES

REPORTS OF OFFICERS

House of Delegates,
Indiana State Medical Association.
Gentlemen:

After carefully considering the report of each officer we beg to present the following:

PRESIDENT. Under the able leadership of President Weinstein, the State Association during the past year (borrowing from his presidential address) has been piloted among the rocks of many experimental reforms such as contract medicine, health and hospital insurance, and others. Much to his credit be it said that he has preserved an even keel despite the barnacles of lay theorists and selfish individuals and groups. This has not been accomplished for the medical profession of Indiana without much time and great effort. No man who has held this honor has met greater difficulties or faced them with greater confidence and accomplishment. We may well heed his advice as to eternal vigilance on the part of the profession against tampering of outside interests, and above all else our personal and group conduct in matters of public health and publicity. He has stated many times that the medical profession in this state has been entrusted with its own problems as never before and we alone are responsible for success or failure.

PRESIDENT-ELECT. President-elect Padgett has outlined an ambitious and commendable program. His emphatic confidence in support of the new legislation concerning public health management and the care of the indigent sick means support and stimulation for individual county societies in their problems. His opposition to lay interference in medicine, to group hospitalization, contract medicine and care of pay patients in tax-supported hospitals is sound and should be supported by the members of the profession.

We wish to commend his attitude regarding postgraduate or instructional work and express the hope that it may be improved and possibly combined with the state meeting as optional instruction courses. We wish to express every confidence that when Dr. Padgett's report is turned in at the next annual meeting it will not be found wanting in any respect.

TREASURER. The report of the treasurer suggests to the society that a combined audit of the society affairs and THE JOURNAL, if made at the end of THE JOURNAL'S fiscal year, will eliminate a double audit and no doubt save some expense for the society. Your committee therefore recommends that the books of the society be closed on December thirty-first. In this way a full report of the society and JOURNAL affairs can be made at each annual meeting.

DELEGATES TO A. M. A. The report of the delegates to the American Medical Association was of interest to the House of Delegates and we commend the president for inviting them as ex-officio members of the House of Delegates, and suggest that continuance of this precedent will be mutually helpful.

COUNCIL REPORT. While it is impossible to comment upon the many excellent measures carried out by the Council and Executive Committee, we wish especially to mention the concentration of the executive offices and THE JOURNAL and the selection of an editorial board. This concentration of society activities will undoubtedly increase efficiency and decrease expense. The influence of the editorial board undoubtedly will make an already outstanding journal of more value to the rank and file of the profession.

SECRETARY. The modest report of Mr. Hendricks touching as it does the high spots of progress in medicine for Indiana, most of which have been covered in other reports, and giving the credit to the various officers and committees, is characteristic of the man who accomplishes things. Your committee wishes to say that in its opinion no other single personal factor has added as much to medical progress in Indiana and to the professional and financial benefit of the doctor as the work of Mr. Hendricks.

JOHN CARMACK, *Chairman.*
W. E. JENKINSON.
EARL VANREED.
T. Z. BALL.
J. D. STURDEVANT.

On motion of Dr. Carmack, duly seconded, the report was adopted.

SECTIONS AND SECTION WORK

To the House of Delegates,
Indiana State Medical Association.
Gentlemen:

Your Committee on Sections and Section Work begs to report that the present method of presenting our scientific program in sections and general sections is very satisfactory and we advise no change.

Also regarding the resolution to change the date of the annual meeting, we advise it be placed with the Executive Committee to make such change in date as seems necessary.

V. S. TURLEY, *Chairman.*
B. J. LARKIN.
R. L. COMPTON.
BOYD BURKHARDT.
C. F. FLETCHER.

Dr. Larkin moved that this report be accepted as read; motion seconded, and carried.

RULES AND ORDER OF BUSINESS

DR. GEORGE DETAR: As nothing was referred to this committee, we have nothing to report at this time.

MEDICAL EDUCATION AND HOSPITALS

To the House of Delegates,
Indiana State Medical Association.
Gentlemen:

The report of the Committee on Medical Education and Hospitals gives an illuminating discussion of the present situation of the county hospitals of the state. The report needs to be read and re-read to get its full import. It is informative and advisory and urges the members of our Association to lend a hand in solving the problems of so many empty hospital beds.

Many county hospitals are serving their community interests well and will continue to do so. The handicaps peculiar to these institutions are well pointed out in the report as printed. In view of the difficulties encountered by some institutions of this class it would seem wise to survey carefully all phases of individual cases before encouraging the erection of new hospitals of this kind.

A general reduction in hospital charges is highly desirable if not imperative. Patients of moderate means are being driven into charity hospitals. This reduces the hospital income and the physicians' income (particularly of those physicians whose practice is largely a hospital practice) and is distinctly unfair to many persons anxious to continue under the care of a personal and private physician. Hospital care, on account of extra charges assessed, even for the most insignificant items, is now a burden of unproportionate size to practically all classes of patients. The room charge means very little in arriving at a guess as to the hospital bill. In fact, it is not possible under this system to estimate accurately the probable hospital expense. When after one or two weeks of hospital care the charges reach totally unexpected amounts, the physician may be blamed for the unexpected size of the bill by the unhappy and worried patient and his family.

It is unfair to continue the overcharges made necessary by overbuilt and overmanned hospitals. It is not right to add to the burdens of charity hospitals by denying a reasonable rate to those persons who can and will pay a small amount for hospital services.

This committee recommends that the standing Committee on Medical Education and Hospitals study and report on this phase of medical practice during the ensuing year.

We appreciate the comment on the correction of the former policy in regard to veterans' relief, and the enactment of the last legislature making it possible for dependent children to be placed in local hospitals.

We concur in the report on group hospitalization, or hospital insurance. The conclusion of this report may be emphasized, "that cooperative group hospitalization at the present time is an experiment and should not be recommended."

We believe the comment on the salaries of the doctor, workers and teachers in connection with Indiana University Medical School at Indianapolis to be sound.

We move the adoption of the report as a whole.

REPORT OF COMMITTEE ON POSTGRADUATE STUDY. Your reference committee approves the report of the Committee on Postgraduate Study and moves its adoption.

REPORT OF THE COMMITTEE ON BUSINESS INSTRUCTIONAL COURSE. Your reference committee on the Report of the Committee on Business Instructional Course agrees in the main with the report. We do not exactly see the need of the permanency of the committee as recommended.

This idea, i.e., of instituting a business instructional course, having been adopted by the Indiana University Medical School, it seems unnecessary to have a special committee. Details may safely be left in the hands of the faculty dealing with the curriculum.

However, we concur in the basic idea of the report and move its adoption.

Respectfully submitted,
A. C. YODER, *Chairman.*
W. D. LITTLE.
MAURICE C. MCKAIN.
D. W. SCHAFER.
E. L. SCHAIBLE.

Dr. Yoder moved the adoption of all sections of this report; motion seconded and carried.

LEGISLATION

House of Delegates,
Indiana State Medical Association.
Gentlemen:

1. We recommend the acceptance of the report of the Committee on Legislation and Public Policy, and wish to call special attention to their comment on the new set-up of the State Board of Health, maintenance of the present status of the State Board of Medical Registration and Examination, and Riley Hospital patients. The conclusions should be studied carefully and endorsed by the House of Delegates.

2. We consider that the Registration Committee has performed its full duty in ascertaining the facts pertaining to the annual registration of licensed practitioners. While such registration would undoubtedly work to the benefit of the physician, we deem it inadvisable to urge any legislation to this end at the present time.

3. In regard to the report of the Committee on Study of Health Insurance, we recommend the adoption of the resolution suggested by them with two corrections. One correction

is that the proper name of the Indiana State Medical Association be substituted in place of the designation "Indiana State Medical Society," wherever used. The other correction is that the word "be" be substituted for the word "become" in the first part of the resolution, making this paragraph read: "*Be it Resolved*, That no member of the Indiana State Medical Association may be allied with an organization whose purpose is to supply medical service to a group of individuals, unless the said organization is approved by the Executive Committee of the Indiana State Medical Association."

4. We approve the adoption of the report of the special Committee on Medical Care of the Indigent, except that in our opinion there should be no discrimination in the percentage of the fees paid for different types of professional service, and that the provision recommending rotation of service among physicians is in conflict with the policy of allowing the patient free choice of physician. Section 3, Plan Three, should, therefore, read as follows:

(3) Establishment of a fee schedule representing approximately 50 per cent of regular fees.

And Section 5, Plan Three, should be deleted.

Respectfully submitted,
O. G. BRUBAKER, *Chairman.*
PAUL A. GARBER.
A. W. CAVINS.
W. F. KELLY.
M. L. MCCLAIN.

THE CHAIRMAN: In regard to section 3 of the above report I want to call your attention to the fact that this recommendation will really have effect on the Constitution and By-Laws. So keep that in mind in voting.

DR. W. F. KELLY: Do I understand that if this report is approved that that resolution is approved and adopted?

THE CHAIRMAN: Yes.

DR. KELLY: Don't you think it would be a good plan to have the whole resolution read so that the members will know what it is about?

THE CHAIRMAN: What is the desire of the House?

The motion made to this effect was lost.

On motions duly made and seconded the various sections of this report were approved, and on motion of Dr. O. G. Brubaker, duly seconded, the report as a whole was adopted.

PUBLIC POLICY

Mr. President:

Your reference Committee on Public Policy has studied the report of the standing Committee on Civic and Industrial Relations. We commend the committee for the excellent work that it has accomplished, and as it is not completed to their satisfaction, we recommend that the committee be continued for another year. I move you, Mr. President, that the report of the committee be accepted with this recommendation.

Your reference Committee on Public Policy has read the report of the standing Committee on Veterans' Hospitalization and finds it completed. Inasmuch as there may be future contingencies arise, we recommend that the committee's report be accepted, and this committee be continued for another year to act in case anything arises requiring their consideration. I move you, Mr. President, that the report of this committee be accepted with this recommendation.

Your reference Committee on Public Policy has carefully read the report of the standing Committee on Public Relations, and highly commends them on the thoroughness in which they have completed their work, especially relative to admission and charges for patients admitted to the Riley and Coleman Hospitals. I move you, Mr. President, that the report of the committee be accepted.

J. W. SHAFER, *Chairman.*
H. G. HAMER.
P. J. BIRMINGHAM.
CLAUDE DOLLENS.
R. W. BRUNER.

The paragraphs of this report were voted on and adopted separately. On motion of Dr. J. W. Shafer, duly seconded, the report was adopted as a whole.

PUBLICITY

House of Delegates,
Indiana State Medical Association.
Gentlemen:

Your reference Committee on Publicity wishes to make the following report:

First, we concur in the report of the Bureau of Publicity and recommend the adoption as published. No group of men in the Association devote as much time to their work as the members of this Bureau, spending one afternoon of every week, and yet we as delegates scarcely take the time to read in detail the fourteen pages of the report. What other activity of our Association ranks any ways near in attracting the attention and envy of the other constituent state units of the American Medical Association? If not the pioneer, it is the model for the nation. Our gratitude has been expressed in glowing terms each year of its existence and no further words could add to our indebtedness. We can only give devout thanks to a kind Providence that has extended the life of Dr. W. N. Wishard so that he and Dr. Clark and Dr. Stygall could round out another year of fruit-bearing endeavor. May we again urge every member to cooperate in keeping our publicity on a high ethical plane, and particularly in submerging all personal mention in radio releases?

Second, we advise acceptance of the report of the special Committee on Exhibit at the State Fair. The fact that 25,000 people studied this exhibit is sufficient praise for the committee and is ample justification for our recommendation that this exhibit be repeated next year. Doubtless many of the sightseers were lured by the free blood pressure readings, but may we suggest that careful consideration be given to a more subtle method of inducing the visitors to consult their family physicians?

CHARLES N. COMBS, *Chairman.*
I. N. TRENT.
C. M. CLARK.
V. V. CAMERON.
J. E. FERRELL.

Dr. Combs moved the adoption of this report; motion seconded and carried.

HYGIENE AND PUBLIC HEALTH

House of Delegates,
Indiana State Medical Association.
Gentlemen:

Your Committee on Hygiene and Public Health approves the reports of the Diphtheria Committee, the special Committee on Study of High School Athletics, the special Committee on Lye Burns in Children, and the special Committee for the Study of Puerperal Mortality as printed in the Indiana State Medical Association JOURNAL.

F. W. BLACK, *Chairman.*
E. O. ASHER.
C. J. ADAMS.
A. S. NEWELL.
C. J. CLARK.

Dr. Black moved the adoption of this report; motion seconded and carried.

AMENDMENTS TO CONSTITUTION AND BY-LAWS

House of Delegates,
Indiana State Medical Association.
Gentlemen:

REPORT OF COMMITTEE ON SPECIAL MEDICAL DEFENSE FUND. The report of the Committee on Special Medical Defense Fund was studied by this reference committee in the light of the past twenty years' experience. The suggested changes have been before this House of Delegates in other years.

I. The proposal that the Special Defense Funds be kept as a separate fund is in line with the present provision of the by-laws. We are informed that the moneys in question are so kept by our treasurer, Dr. Weyerbacher.

II. The reference committee is of the opinion that it would be inadvisable for the State Association to assume indemnity liability. Such an effort would put the Association in the insurance business and subject to the supervision of the Insur-

ance Department of the state. It would make the Association subject to taxes which it is not under the present plan.

III. The committee feels, however, that it would not be improper for the Defense Fund to carry its proper share of administrative expense. This, we understand, has not been the policy in the past and accounts in part for the size of the present sum now carried as medical defense fund and surplus.

The reference committee recommends that the present plan of operation of the medical defense provisions of our by-laws be continued without change.

We move the adoption of this part of the committee report. Motion seconded, and carried.

THE CHAIRMAN: The question that is before the House at the present time is the vote on the amendment to the amendment to the By-Laws. The amendment presented last year was in reality a substitute amendment which substituted one paragraph for another and so your chair will call it a substitute amendment. The question will be, shall we substitute the one paragraph for the other? I will ask our secretary to read the original By-Law, then the amendment as presented, then the substitute amendment as presented.

THE SECRETARY: Section 4, Chapter XII, of the By-Laws of the Indiana State Medical Association, adopted 1926 and amended September, 1928, reads as follows:

"The Treasurer of the Indiana State Medical Association shall be custodian of the Defense Fund, separately kept, and shall give such additional bond as may be demanded by the Medical Defense Committee. He shall pay out money from this fund only on the signed order of the Chairman of the Executive Committee and countersigned by the President and the Chairman of the Council."

THE CHAIRMAN: The recommendation of our reference committee is that that not be changed.

THE SECRETARY: Amendment to Section 4, Chapter XII, of the By-Laws as printed in the September, 1932, issue of THE JOURNAL.

"The Treasurer of the Indiana State Medical Association shall be custodian of the Defense Fund, separately kept, and shall give such additional bond as may be demanded by the Medical Defense Committee. He shall pay out money from this fund only on the signed order of the Chairman of the Executive Committee and countersigned by the President and Chairman of the Council. If the amount of money in the Defense Fund accumulates to an amount larger than is necessary for the purposes of the Defense Fund, in the judgment of the Executive Committee, the Executive Committee may, by a majority vote of the Committee, authorize the Treasurer of the Association to transfer such surplus above the amount deemed by the Executive Committee to be necessary for the Defense Fund, to the general funds of the Association, and such surplus shall thereupon be so transferred."

The substitute amendment follows:

"Paragraph 1 to read as printed in the September, 1932, issue of THE JOURNAL of the Indiana State Medical Association.

"Section 4, strike out rest of amendment beginning with word 'if,' line 8, and ending with word 'transferred,' line 16, and insert the following in lieu thereof:

" 'Any surplus in the Medical Defense Fund at the end of the Association's fiscal year, over and above five hundred ($500.00) dollars is to be invested or deposited at interest for the Indiana State Medical Association by the Executive Committee. Said investments or deposits are to show that they were made from and belong to the Medical Defense Fund. All of said funds as defined in Chapter XII, Section 1, of the By-Laws of the Indiana State Medical Association, together with all profits from investments or interest from deposits, shall constitute "A Special Fund for Medical Defense." No part nor all of said fund may be transferred to any other fund or used for any other purposes than those set forth in Chapter XII of the By-Laws of the Indiana State Medical Association.' "

THE CHAIRMAN: You have heard the reading of the amendment and the substitute amendment. Any remarks?

DR. S. P. HOFFMANN: A year ago this amendment was introduced by the Executive Committee of this state organization and it definitely sets forth the purpose for which it was presented—to give the Executive Committee power to transfer whenever it sees fit such surplus above that deemed to be necessary for the defense fund to the general funds of the Association. I made an amendment to that amendment which is not a substitute amendment, and it would make no difference whether it was or not because the Roberts Rules of Order under which this organization works, permits the striking out of a phrase, a word, or an entire paragraph. The amendment which I made intends to keep in the medical defense fund that money which is paid into the fund by the members, for that purpose. It is merely my intention to keep that fund there. There is nothing in the amendment which says we shall go into the insurance business. I merely wish to keep that money in the fund. My amendment is made to an amendment which made it possible to divert that money. I move that this amendment to the amendment be made a special order of business at this time. (Motion seconded by Dr. VanBuskirk and carried.)

THE CHAIRMAN: We will now proceed to vote on the substitution of the one paragraph for the other. All in favor of substituting the paragraph read by Mr. Hendricks last for the paragraph read by Mr. Hendricks first will please say aye. Opposed no. (Carried.)

The question before the House is the adoption of the amendment as amended, or properly putting it, the adoption of the substitute amendment just now approved by the House.

DR. W. H. STEMM: In voting for this do we keep the present defense fund intact?

THE CHAIRMAN: Yes. We will have Mr. Hendricks read the amendment to the amendment again that all delegates may be familiar with the question before the House.

THE SECRETARY:

"Paragraph 1 to read as printed in the September, 1932, issue of THE JOURNAL of the Indiana State Medical Association.

"Section 4, strike out rest of amendment beginning with word 'if,' line 8, and ending with word 'transferred,' line 16, and insert the following in lieu thereof:

" 'Any surplus in the Medical Defense Fund at the end of the Association's fiscal year, over and above five hundred ($500.00) dollars is to be invested or deposited at interest for the Indiana State Medical Association by the Executive Committee. Said investments or deposits are to show that they were made from and belong to the Medical Defense Fund. All of said funds as defined in Chapter XII, Section 1, of the By-Laws of the Indiana State Medical Association, together with all profits from investments or interest from deposits, shall constitute "A Special Fund for Medical Defense." No part nor all of said fund may be transferred to any other fund or used for any other purposes than those set forth in Chapter XII of the By-Laws of the Indiana State Medical Association.' "

THE CHAIRMAN: The present by-law keeps the fund intact. It will not be disturbed either way. The amendment which we are to vote upon right now changes the wording of the old by-law and mandates the Executive Committee to do certain things with that fund.

THE SECRETARY reads the old by-law:

"The Treasurer of the Indiana State Medical Association shall be custodian of the Defense Fund, separately kept, and shall give such additional bond as may be demanded by the Medical Defense Committee. He shall pay out money from this fund only on the signed order of the Chairman of the Executive Committee and countersigned by the President and the Chairman of the Council."

Now the amendment to the amendment is:

"Any surplus in the Medical Defense Fund at the end of the Association's fiscal year, over and above five hundred ($500.00) dollars is to be invested or deposited at interest for the Indiana State Medical Association by the Executive Committee. Said investments or deposits are to show that they were made from and belong to the Medical Defense Fund. All of said funds as defined in Chapter XII, Section

1, of the By-Laws of the Indiana State Medical Association, together with all profits from investments or interest from deposits, shall constitute 'A Special Fund for Medical Defense.' No part nor all of said fund may be transferred to any other fund or used for any other purposes than those set forth in Chapter XII of the By-Laws of the Indiana State Medical Association."

DR. F. S. CROCKETT: It seems to me we are all a bit confused. Perhaps this might be a clarifying statement. As I understand it, the present provision is that we should keep $6,000 as a reserve for the defense fund and in addition to that any surplus which it seems wise by the Executive Committee. That is the present method of doing business. The new method proposed by Dr. Hoffmann says that all moneys coming in must be kept for defense purposes alone and no matter how much the surplus is it must be kept for that purpose. The reason why the committee put in "indemnity liability" is because of the words contained in Dr. Hoffmann's report: "Gentlemen, this fund should remain intact, it should ever be kept as a medical defense fund; it should be the beginning of a fund which when times become better and a larger fee may be assessed the fund will be large enough that it may take on the full duties of defense and the payment of indemnities or judgments assessed."

Mr. President, it seems to me we have to leave the business of this Association in the hands of the Executive Committee and the Council unless they come forward and want a change. I am rather of the opinion that we should leave it alone, leave it as it is. I should like to hear from Dr. Weyerbacher.

DR. A. F. WEYERBACHER: I think the remarks of Dr. Crockett clear up the issue. The State Association furnishes medical defense and pays no indemnity. There is embodied in the committee's report a rather vague reference that we should undertake to pay damages. It is the opinion of the Executive Committee that we do not want to go into the insurance business. It would take a tremendous amount of money to do that. It has been satisfactory as it is. Should we go into the insurance business we would be compelled to pay state taxes and we would be subject to the dictates of the state insurance department. My personal feeling is that we should not undertake the paying of indemnities.

DR. W. R. DAVIDSON: I would like to call the attention of the House to the fact that such a resolution would mix up constitutional and statutory laws, the insertion of regulatory law into constitutional law. I believe the original by-laws should prevail. This was originated for one specific purpose, not for the purpose of accumulating funds that could be diverted.

DR. HERMAN BAKER: As a member of the committee which spent several hours in going over this thing, I should like to emphasize the point that Dr. Davidson made. This fund was originally created for a certain purpose and it was the feeling of the committee that any regulatory laws that may be inserted at this time would interfere with the original intent. That was the point that the committee had in mind in recommending that the original by-law be retained as it was originally written.

THE CHAIRMAN: The question is upon the adoption of the amendment as amended.

(On a rising vote the motion for adoption was lost.)

Report of reference Committee on Amendments to Constitution and By-Laws continued:

RESOLUTION INTRODUCED BY DR. HARE. Your reference committee is in full sympathy with any effort to improve and popularize the courses of intensive study conducted by our Association throughout the state. We are of the opinion, however, that this is a distinct and separate Association activity. We doubt if these courses of study would attract our members in greater numbers or be more appreciated if the nominal attendance fee was omitted. On the contrary we feel that the experiences of the past two years support our belief that the payment of a nominal fee has not prevented attendance by anyone desirous of profiting by the course of study. The Executive Committee has provided that any surplus accruing from these courses of study shall be kept in a separate fund for use in future courses. We recommend and move that this resolution be not adopted. (Motion duly seconded, and carried.)

AMENDMENT TO BY-LAWS INTRODUCED BY DR. W. F. KELLY: Your reference committee in considering the proposed amendment to Chapter VIII, Section 1, of the By-Laws concludes it impossible in the short time available to reach a matured judgment concerning the desirability of increasing the number of standing committees.

We would call attention to the present wording of a part of Chapter VIII, Section 1, "The President also may appoint such other committees as may be necessary." We believe that the By-Laws already provide the authority proposed by this resolution.

We move that this resolution be laid over one year and referred to the Executive Committee for study and recommendation at the next annual session. (Motion duly seconded, and carried.)

W. N. WISHARD, *Chairman.*
F. S. CROCKETT.
B. G. KEENEY.
V. E. HARMON.
H. M. BAKER.

Dr. Crockett moved the adoption of the report as a whole; motion seconded and carried.

CREDENTIALS

Members of the House of Delegates:

Your Committee on Credentials moves the adoption of the report as printed in THE JOURNAL of the Indiana State Medical Association.

S. P. HOFFMANN, *Chairman.*
H. D. CAYLOR.
H. W. GARTON.
G. R. DANIELS.
J. S. KETCHAM.

Moved by Dr. Hoffmann that the report be adopted; motion duly seconded, and carried.

MISCELLANEOUS BUSINESS

Mr. President:

The Committee on Miscellaneous Business begs to submit the following report:

First: The comprehensive and instructive report of the Committee on Necrology is approved *cum laude*, and we move that it be accepted.

Second: The report of the Committee on Secretaries' Conference is approved and we move that it be accepted.

Third: The resolution presented by Dr. Clark relative to instructing our national delegates to try to have the national society send a committee to the National Insurance Underwriters' Association to arrange for a fee to be paid for filling out the final papers at the death of their policyholders, is approved and we move that it be accepted.

HARRY W. HELMEN, *Chairman.*
O. R. SPIGLER.
J. H. CROWDER.
W. A. THOMPSON.
C. F. HOPE.

Dr. Helmen made a motion that the report be adopted as a whole; motion seconded, and carried.

THE CHAIRMAN: Are there any resolutions to be presented at this time?

DR. W. R. DAVIDSON: I would like to make a motion to have the secretary prepare the formal resolutions to the Orange County and the Third District Medical Societies—Dr. Dillinger and Dr. Ragsdale—their wives and daughters, also to Mr. Fawcett and Mr. Tom Taggart, and to the Indianapolis News, and to Mr. Bill Herschell and also the efforts of our retiring president. (Motion duly seconded and carried.)

THE PRESIDENT: This brings us up to the close of business for this meeting. In closing I want to express my appreciation for the wholehearted and earnest cooperation that all of the officers and all of the members and all of the committees have given me this past year. It is really impossible for me to tell

you what is inside of me as to how you have worked with me, the support you have given me, and as I said yesterday, my fondest wish for your incoming president is that he may have the hearty support and cooperation you have given me. It has been an outstanding thing in my eventful life. I want to now pass the gavel over to our incoming president and I know that he has everything in hand and can carry straight along.

DR. E. E. PADGETT: I am not hesitating in the work that is before us. You know and I know and we all know that I am undertaking to follow a couple of the hottest men that have ever been in this place. However, the pace they have set has been an education, a training for all of us. The things I gave you the other afternoon are only the things we have seen. There will be plenty of others that we will see before we get very far along. I feel very definitely that the State Association is in dead earnest. A man said yesterday, "Dr. Padgett, I have never seen this Association working like it is working at this meeting." That is the best thing that we can carry home from this meeting. I ask that you men stand together; if you stand together among yourselves we will have no trouble in getting along, especially since I have had such a good man going before me and such a good man to succeed me. I ask your hearty cooperation.

THE PRESIDENT: There being no further business, we will stand adjourned.

The House of Delegates of the Indiana State Medical Association adjourned *sine die*.

MINUTES OF GENERAL MEETINGS

The first General Meeting convened Tuesday afternoon, September 26, following the Economic Conference. Dr. J. H. Weinstein, Terre Haute, presided.

Dr. George R. Dillinger, French Lick, presented greetings from the Committee on Arrangements.

Dr. H. C. Ragsdale, of Bedford, introduced Dr. Morris Fishbein, editor of *The Journal* of the A. M. A., who commented upon the work done in Indiana in caring for the indigent sick.

Dr. Joseph H. Weinstein, Terre Haute, read the President's Address.

Dr. John H. Warvel, Indianapolis, read a paper entitled "Management of Diabetes." Discussed by Dr. Gayle J. Hunt, Richmond.

Dr. Alois L. Ziliak, Princeton, read a paper entitled "Cancer: Etiological Conditions." Discussed by Dr. Virgil McCarty, Princeton.

Drs. M. H. Foster, L. H. Gilman, and Rogers Smith of Indianapolis presented "Epidemic Encephalitis at St. Louis." Discussed by Drs. R. R. Pierson, New Albany; Larue D. Carter, Indianapolis, and L. H. Gilman.

Dr. Howard C. Ballenger, Chicago, read a paper entitled "Otolaryngology in General Practice." No discussion.

Dr. Carl P. Schoen, New Albany, read a paper entitled "Postoperative Atelectasis." No discussion.

Wednesday, September 27, 2 p. m.

The second General Meeting convened at 2 p. m. Wednesday, with the President, Dr. J. H. Weinstein, in the chair.

Dr. Arthur Hale Curtis, Chicago, read a paper entitled "Special Features in the Etiology and Diagnosis of Cancer of the Uterus: Treatment." Discussed by Drs. F. C. Walker, Indianapolis; J. R. Pugh, Hammond, and Arthur H. Curtis.

Dr. Louis Jacob Hirschman, Detroit, read a paper entitled "The Proctologist Looks at Focal Infection." Discussed by Drs. A. B. Graham, Indianapolis; H. H. Wheeler, Indianapolis; Granville R. Hanes, Louisville, Ky., and L. J. Hirschman.

Dr. Ernest Sachs, St. Louis, read a paper entitled "Brain Tumors." Discussed by Drs. E. Vernon Hahn, Indianapolis; J. R. Pugh, Hammond; M. Casper, Louisville, Ky., and Ernest Sachs.

The President extended the thanks of the Association to the invited guests and all those who had helped to make the program a success.

The Indiana State Medical Association adjourned *sine die*.

MINUTES ECONOMIC ROUND TABLE

Tuesday, September 26, 1933

The Economic Round Table Conference occupied the lunch hour and part of the afternoon program, with the following participants:

Governor Paul V. McNutt.

William H. Book, Director of the Governor's Commission on Unemployment Relief. Discussed by Drs. F. S. Crockett, Lafayette; S. P. Hoffman, Allen County; Joseph H. Weinstein, Vigo County; W. A. Thompson, Union County; H. D. Caylor, Wells County; J. R. Crowder, Sullivan County; E. O. Harrold, Grant County.

Walter F. Kelly, Indianapolis, State Committee for Investigation of Various Insurance Schemes.

W. D. Gatch, "Indiana University Medical School and the Doctor in Practice."

Paul Johnson, Richmond, "The County General Hospital in Relation to Group Hospitalization."

A. W. Cavins, Terre Haute, "Report of Survey of Various Counties as to Care of the Indigent."

Dr. Paul Garber, Whiting, introduced Mr. Peabody, South Whitley, the editor of a lay journal for the exposure of quackery.

A. M. Mitchell, Terre Haute, "How Members can Cooperate with County Secretaries."

MINUTES OF MEDICAL SECTION

Wednesday, September 27, 1933

The Medical Section convened at 9 a. m., September 27, the chairman, Dr. R. L. Sensenich of South Bend, presiding.

Dr. Bayard G. Keeney, Shelbyville, read a paper entitled "The Determinants of Kidney Function." No discussion.

Dr. Cecil Logan Rudesill, Indianapolis, read a paper entitled "Differential Diagnosis of Biliary Diseases." Discussed by Drs. Walter F. Carver, Albion, and C. L. Rudesill.

Dr. John Eric Dalton, Indianapolis, read a paper entitled "Lymphogranulomatosis Inguinalis." Discussed by Dr. A. S. Giordano, South Bend.

Dr. Russell Allen Flack, Lafayette, read a paper entitled "Coronary Occlusion." Discussed by Drs. F. E. Sayers, Terre Haute, and Walter L. Bierring, Des Moines, Iowa.

Dr. Pierce MacKenzie, Evansville, read a paper entitled "Diet and Fluids in Pregnancy." Discussed by Dr. K. M. Beierlein, Fort Wayne.

Election of officers resulted as follows:

Chairman, C. J. Clark, Indianapolis.

Vice-Chairman, B. S. Cornell, Fort Wayne.

Secretary, A. S. Giordano, South Bend.

MINUTES OF THE SURGICAL SECTION

Wednesday, September 27, 1933

The Surgical Section convened at 9 a. m., with the chairman, Dr. E. Vernon Hahn of Indianapolis, in the chair.

Dr. James Y. Welborn, Evansville, read a paper entitled "Treatment of Fractures." Discussed by Drs. E. V. Wiseman of Greencastle; Edward T. Stahl, Lafayette; Robert A. Milliken, Indianapolis; Cleon A. Nafe, Indianapolis, and J. R. Pugh, Hammond.

Dr. Frank H. Jett, Terre Haute, read a paper entitled "Aseptic Treatment of Primary Wounds." Discussed by Drs. Joseph H. Clevenger, Muncie; James Y. Welborn, Evansville, and E. V. Wiseman, Greencastle.

Dr. M. F. Sexton, Rushville, read a paper entitled "Experience with Spinal Anaesthesia." Discussed by Drs. Frank B. Ramsey, Indianapolis; C. N. Combs, Terre Haute; Don Cameron, Fort Wayne, and C. R. Pettibone, Crown Point.

Dr. N. K. Forster, Hammond, read a paper entitled "Consideration in the Management of Functional Disturbances of Menstruation." Discussed by Drs. S. P. Hoffman, Fort Wayne; Arthur H. Curtis, Chicago; F. C. Walker, Indianapolis; H. L. Miller, West Baden, and N. K. Forster.

The election of officers resulted as follows:

Chairman, H. C. Ragsdale, Bedford.

Vice-Chairman, Don Cameron, Fort Wayne.

Secretary, William C. Reed, Bloomington.

MINUTES OF THE SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY

The Section on Ophthalmology and Otolaryngology convened at 9:15 Wednesday morning, September 27. Dr. William S. Tomlin of Indianapolis presided.

The chairman's address was dispensed with and officers were elected as follows:

Chairman, Dr. J. R. Gillum, Terre Haute.
Vice-Chairman, Dr. C. Norman Howard, Warsaw.
Secretary, Dr. Raymond Calvert, Lafayette.

Paper prepared by Dr. Raymond C. Beeler and Dr. James N. Collins of Indianapolis, read by Dr. Collins. The paper was entitled "The Diagnosis of Maxillary Sinusitis by the Use of Opaque Oils." Discussed by Drs. W. E. Stewart, Terre Haute; J. W. Carmack, Indianapolis; F. V. Overman, Indianapolis; H. A. Van Osdol, Indianapolis; H. C. Ballenger, Chicago; D. O. Kearby, Indianapolis, and J. N. Collins.

Paper presented by Dr. Eugene L. Bulson of Fort Wayne. Subject: "Malignant Disease of the Larynx; Peroral Endoscopy as an Indispensable Aid in Its Early Diagnosis." Discussed by Drs. J. V. Cassady, South Bend; D. O. Kearby, Indianapolis; J. F. Barnhill, Indianapolis; Bernard Ravdin, Evansville, and E. L. Bulson.

Paper presented by Dr. James C. Carter of Indianapolis. Subject: "The Pediatrician and the Otolaryngologist." Discussed by Drs. A. F. Clements, Evansville; F. V. Overman, Indianapolis; J. W. Carmack, Indianapolis; J. F. Barnhill, Indianapolis; J. V. Cassady, South Bend; R. A. Craig, Kokomo, and J. C. Carter.

Paper presented by Dr. E. W. Dyar of Indianapolis. Subject: "The Value of Perimetry in Ocular Diagnosis and Prognosis." Discussed by Drs. L. L. Nesbit, Lafayette; Bernard Ravdin, Evansville, and E. W. Dyar.

The Section on Ophthalomology and Otolaryngology adjourned at 12:30 p. m.

THE INDIANA STATE MEDICAL ASSOCIATION

EXECUTIVE COMMITTEE

FRENCH LICK, INDIANA,
September 24, 1933.

Meeting called to order at 8:15 p. m.

Roll call showed the following present: W. H. Kennedy, M. D., chairman; H. H. Wheeler, M. D.; J. H. Weinstein, M. D.; O. O. Alexander, M. D.; A. F. Weyerbacher, M. D.; E. M. Shanklin, M. D., and T. A. Hendricks, executive secretary.

Membership Report

Number of members on August 31, 1933	2,575
Number of members on August 31, 1932	2,693
Loss over last year	118
Number of members on September 23, 1933	2,616
Number of members on September 23, 1932	2,707
Loss over last year	91
Number of members on December 31, 1932	2,724

Speakers' Table

In accordanee with the ruling of the committee the following will sit at the speakers' table at the annual banquet:

State Association officers:
President
President-elect
President-elect-elect (if banquet comes after last meeting of House of Delegates)
Past president (to receive certificate of merit)
Treasurer
Chairman of Council
Editor of THE JOURNAL
Chairman of Executive Committee

Local: General Chairman of Local Arrangements
President of local society
Secretary of local society
Councilor of the district

Eminent guests:
Dean of medical school
Outstate essayists and speakers

The committee desired a reporter on the economic conference and authorized the secretary to obtain the services of Miss Dillan.

State Society Dues

An investigation made by the American Medical Association shows that the Indiana state dues of $7.00 are below the average charge made throughout the country. Aside from a few southern and far western states and a few less populous eastern states, there are only a few states, Ohio and Pennsylvania, with dues lower than Indiana, which give services that can be compared to those received by the individual physician through the medical organization in Indiana. These states have two or three times as many physicians as has Indiana. Outside of these no state in the country gives services such as medical defense, an active economic program, a state medical journal, and an attempt at a publicity program, whose dues are less than those in Indiana.

University Hospitals

The report of the Public Relations Committee upon the use of the rooms for private patients in the University Hospitals appeared in the September number of THE JOURNAL and was acted upon favorably by the House of Delegates.

Group Hospitalization

A fall crop of these plans has sprung up in Indiana.

(1) Credit Union plan proposed by Dr. U. C. Ambrose, superintendent of the Indiana Christian Hospital, brought to the attention of the committee, along with a letter of criticism by Dr. Leland. This plan, along with Dr. Leland's criticism, had been sent by the headquarter's office to the secretary of the Indianapolis Medical Society.

(2) Criticism of contracts of the United Pacific Casualty Insurance Company, in force by physicians in Seattle, presented to the committee.

(3) Greater Boston Hospitalization Plan brought to the attention of the committee.

(4) Plan of E. J. Bryan, Journal Square Station, Jersey City, New Jersey. Mr. Bryan called at headquarter's office and was told that he must have the approval of Dr. R. G. Leland and the American Medical Association before talking to the Indiana State Medical Association in regard to this.

Contract Practice

(1) A group from Kansas City has come to Indianapolis to attempt to set up a plan of contract practice here. At least one Indianapolis physician has been approached. No details received concerning this as yet.

(2) No further report upon the Employees' Medical Service of Indianapolis.

Indigent Sick

(1) Comments in regard to Indiana set-up received from Doctors West, Leland and Woodward.

(2) Federal Emergency Relief Act Rules and Regulations pamphlet No. 7 received by committee.

American Social Hygiene Association Conference in Indianapolis

Indiana State Medical Association asked to be one of the sponsors and the Executive Committee accepts.

Annual Report of Health Officers

Suggestion made that health officers of each county should make an annual report to each county medical society. The committee thought that this was a worthwhile suggestion but as some of the health officers are laymen it felt that only health officers who are physicians should be asked to make such a report and that an attempt should be made to pass legislation which will make it obligatory for all county health officers

to be physicians. (It has been reported that in several counties the health officers are Christian Science practitioners.) The executive secretary was instructed to get in touch with Dr. Harvey and obtain from him a list of health officers, checking those that are not physicians.

PHYSICIAN NEEDING FINANCIAL AID

Report made that a physician living in Marion County is in need of financial aid. The committee felt that this should be brought to the attention of the local county medical society as it was not a question for the Executive Committee as the physician in question never has been a member of the State Association.

LETTER FROM CENTRAL PRESS CLIPPING SERVICE

The secretary was authorized to make the best arrangements possible under the raised price schedule received from the Central Press Clipping Service. The service for THE JOURNAL and on publicity articles is to be maintained but other service will be discontinued.

THE JOURNAL

(1) Advertising accounts due and past due. Advertising accounts to the amount of $807.75 are past due. The managing editor was authorized to send letters asking that these accounts be paid. A bill is to be submitted for the first quarter. After that bills are to be submitted monthly to all accounts which are past due after the first quarter. After the accounts of commercial firms are past due twice the firms are to be notified that unless they are heard from their advertisement will be dropped from THE JOURNAL and this matter will be taken up through legal sources.

(2) Increased cost of paper for THE JOURNAL. Starting with August a change was made in the paper used in THE JOURNAL. This increased cost of paper has increased the cost of publishing THE JOURNAL.

(3) Free advertisement for Red Cross. The annual Red Cross advertisement is to be run as requested, free of charge.

INDIANA STATE MEDICAL ASSOCIATION BUREAU OF PUBLICITY

August 31, 1933

Meeting called to order at 3:00 p. m.

Present: William N. Wishard, M. D., Chairman; J. H. Stygall, M. D.; E. D. Clark, M. D., and T. A. Hendricks, executive secretary.

Release for publication Monday, September 4, "Good Health Exhibit at State Fair," read and approved.

Dental release for publication August 31, "Tooth Puppets to Play at State Fair Exhibit."

Radio releases:

Saturday, July 1—"July Fourth Injuries."
Saturday, July 8—"Hot Tips on Keeping Cool."
Saturday, July 15—"Infant Care in Warm Weather."
Saturday, July 22—"Chiggers."
Saturday, July 29—"The Common Drinking Cup."
Saturday, August 5—"Protection Against Typhoid Fever."
Saturday, August 12—"Running Water Is Not Always Pure."
Saturday, August 19—"Poison Ivy."
Saturday, August 26—"Lye Preparations as Poisons."

Report on medical meeting:

July 10—Kiwanis Club, French Lick, Ind. "The Underprivileged Child."

The following letter appeared in The Indianapolis News:

"To the Editor of The News:

"Illinois has recently enacted a law penalizing doctors who fail to medicate infants' eyes in the proper manner in the sum of $100, with a jail sentence of six months. This is a step in the right direction, but if there is to be any penalty at all, why stop at such a sentence? There are hundreds of sightless persons in Indiana today whose condition is traceable to wanton neglect by doctors and nurses who have paid no penalty for their culpable carelessness. A prison term of ten years would not be too much to impose either on a neglectful doctor or a nurse suffering from certain types of infection who handles an infant and infects its eyes. If it is argued that there is no need for such a law, the medical profession can have no material objection to its passage. More than half of all blindness today could have been prevented in one way or another. Yet year after year no public effort is made to uproot the chief sources of blindness. When the blind demand aid from the community which has permitted the cause of their condition to exist, they are told that taxes are already too high.

Welfare League for the Blind,
MORRIS B. FIELD."

The Bureau of Publicity prepared the following answer to this letter:

"Several weeks ago in your paper a letter appeared signed 'Welfare League for the Blind, Morris B. Field,' in which doctors and nurses were rather seriously blamed for many cases of blindness.

"To say that 'A prison term of 10 years would not be too much to impose either on a neglectful doctor or a nurse suffering from certain types of infection who handles an infant and infects its eyes,' is absolutely misleading.

"It would seem that your correspondent is grossly misinformed. Ophthalmia neonatorum, the disease to which he refers and the disease which is a very frequent cause of blindness, is primarily a venereal disease and is practically always transmitted to the baby's eyes from the mother's birth canal. The mother may be and often is unaware of her infection, but is entirely able to infect her baby's eyes.

"After conferring with many well known physicians and specialists in obstetrics, as well as eye specialists, we have been unable to trace one single case of this disease in this city to an infected physician or nurse.

"Furthermore it is a standard routine for all physicians or nurses in attendance upon the delivery of babies in this state to cleanse promptly the baby's eyes and treat them with antiseptics in a manner to offer the greatest possible assurance against the transference of the parents' venereal disease germs to the baby's eyes.

"We are in hearty sympathy with any method or procedure which might prevent blindness and are constantly urging that all physicians and all nurses should do all within their power and knowledge to stamp out this serious disease, but we are forced by your correspondent to say that this letter both by direct statement and by inference deviated widely from fact."

The Indiana Congress of Parents and Teachers has asked the Bureau of Publicity to contribute an article each month to the new magazine which is to be published by that organization. The secretary reported that a conference had been held with Mrs. W. J. Hockett, president of the Indiana Congress of Parents and Teachers, and that arrangements had been made to supply the articles desired.

Letter received from the chairman of the General Practitioners' Section of the Columbus Academy of Medicine, Columbus, Ohio, asking for information relative to the success and methods in the periodic health examination movement in this state. The following specific questions were asked:

1. Does the Indiana State Medical Association issue a card to be hung in the office announcing the periodic health examination?

2. Does your association have a standard letter for general practitioners to send or give to their patients stating that the association sponsors this type of service?

The Bureau's answer follows:

"Your letter of August 10 has been brought to the attention of the Bureau of Publicity of the Indiana State Medical Association which has had charge of furthering the periodic health examination movement since its inception several years ago.

"The answers to your two questions follow:

"1. The Indiana State Medical Association does not issue any card to be hung in the physician's office promoting periodic health examinations. On several occasions this matter has been up before the Bureau and it does not ap-

prove of hanging up sueh a card. The Bureau feels that this is an educational problem and should be presented to the public in other ways, through publicity releases and through talks before luneheon clubs, etc. The Bureau feels that if a eard is used it is likely that oecasional individual practitioners will take advantage of it and tell of their own abilities to make these examinations.

"2. The Bureau of Publieity has no form letter whieh has been approved for individual physieians to send out. It however has sent numerous communieations to local societies stating that the state association has sponsored periodic health examinations. In the releases sent out by the Bureau of Publicity no individual physician's name is used. The releases are absolutely impersonal.

"Several years ago the Bureau of Publicity printed and mailed to eaeh individual physician a booklet upon periodic health examinations adopted and recommended by the Ameri-ean Medical Association.

"Under separate cover we are sending you several hand-books of the House of Delegates for past years containing the annual report of the Bureau of Publicity which carries some eomments in regard to periodie health examinations.

"If you have any further questions do not hesitate to write and we will try to answer them. We will be most pleased to receive a eopy of your report when it is completed."

Letter reeeived from the historian of the State Assoeiation thanking the Bureau for the copy of the medical history of Hendricks county supplied by the secretary of the Hendrieks County Medical Soeiety. The secretary was instructed to invite the historian of the Assoeiation to attend the next meeting of the Bureau.

INDIANA DIVISION OF PUBLIC HEALTH

BUREAU OF COMMUNICABLE DISEASES

Monthly Report, September, 1933

Current prevalenee of the prineipal eommunicable diseases indieated by reports from health officers, physieians, and insti-tutions of the state, as compared with the previous month show an increase except in typhoid fever and measles. Positive or negative reports were received from every county in the state. A marked improvement was shown in the accuraey and completeness of the morbidity reports submitted; especially was this true during the second half of the month.

A summary of the diseases from the urban and rural popu-lation is shown below:

Diseases	Total	Urban	Rural
Tuberculosis	125	43	82
Chiekenpox	50	16	34
Measles	7	6	1
Scarlet fever	291	106	185
Smallpox	1	0	1
Typhoid fever	76	19	57
Whooping eough	84	60	24
Diphtheria	129	36	93
Influenza	139	0	139
Pneumonia	10	0	10
Mumps	7	7	0
Poliomyelitis	10	8	2
Meningitis	7	6	1
Encephalitis Lethargica	4	2	2

DIPHTHERIA. Compared with the month of August, a thirty per eent increase was shown in the incidenee of diphtheria during the month of September. For the corresponding month a year ago, one hundred and nine cases were reported. The total for the eurrent month is abnormal for the season, the estimated expeetaney being sixty-three eases. The estimated expectaney is based on the experience of the last seven years. Tippecanoe County led with a total of thirty-one eases. The majority of these eases oecurred at Purdue University, West Lafayette, Indiana.

TYPHOID FEVER. The total of seventy-six cases of typhoid fever reported during September eompares very favorably with the preceding month when ninety-four eases were reported, and also eompares favorably with the total of one hundred and nine cases for the month of September, 1932. The cases re-ported during the current month occurred in thirty-three different eounties, Washington County leading with a total of fourteen cases.

SCARLET FEVER. A seasonal inerease in the ineidenee of searlet fever was antieipated for the month of September; however, the total of two hundred ninety-one cases compared with eighty-two during August, was far beyond our expecta-tion. The cases were widely distributed throughout the state, with only five counties reporting over a total of ten cases for the partieular area. During August of 1932 there were ninety-four eases reported.

MEASLES. A new low level was established for this disease. For the previous month there were thirty cases reported, and twenty-four during the eorresponding month of last year.

INFLUENZA. The total of one hundred thirty-nine cases of influenza for the eurrent month represents an increase over the preceding month, but is not alarming eonsidering the season of the year. Daviess County reported thirty eases out of the total, and Kosciusko County reported thirty-six cases. It is our impression that the health authorities do not con-sider the reporting of this disease as very necessary, reports being submitted only from the rural population. More aecurate reporting of influenza by the health authorities would be ap-preeiated.

MENINGOCOCCUS MENINGITIS. Marion County continues to lead in the number of cases of this disease reported, six out of the total of seven oecurring in that county.

During September, Floyd and Vanderburgh eounties each reported one case of encephalitis lethargiea, and Saint Joseph County reported two eases. We wish at this time again to remind the health authorities of the importance of notifying us immediately of any cases of this disease, and request that a case card be completely filled out for each patient. Crawford, Knox and Tippecanoe eounties eaeh reported one ease of malaria fever. Three eases of paratyphoid fever and ten cases of poliomyelitis were reported.

THURMAN B. RICE, M. D.

CLINTON COUNTY MEDICAL SOCIETY

The Clinton County Medieal Soeiety met in regular session at the Coulter Hotel, Frankfort, Indiana, October 5, 1933, at 5:30 p. m., with Dr. John S. Keteham presiding.

Dr. Charles P. Emerson, of Indianapolis, was the guest of the evening.

The minutes of the meeting of September 7th and the ealled meeting of September 22nd were read and approved.

The report of the committee, declining to aid finaneially the National Anti-Nostrum Soeiety, was read and, upon motion, adopted.

Our alternate delegate, Dr. Keteham, made a report on the state meeting and gave us quite a lengthy report on the ac-tivities of the attempts at poor relief as it oeeupied the atten-tion of the State Society along with the efforts and help of Mr. Book, of the Governor's Relief Commission. He also re-ported that the effort to ehange the amount of our state dues met with failure.

No further business appearing, the meeting was then turned over to Dr. Emerson who presented us with a talk on his experiences while in the East. His subject was "Medicine in the Orient." This talk was very instructive and given in the entertaining manner of which Dr. Emerson seems a past master. That he was attentively received was evideneed by the numerous questions asked and the lively diseussion which fol-lowed his talk. While we may have our own problems, what the other fellow on the other side of the world is doing is still an interesting subject to the men baek home. He told us about the medicine of the Chinese, both old and new, and some of the prescriptions of the old Chinese doctors look rather gruesome until compared with the prescriptions of our early New England settlers, doctors too, by the way, and we sud-denly take up our residenee in Missouri and attempt to forget.

After a vote of thanks and hearty appreciation to Dr.

Emerson for coming among us, and for his endeavors both to entertain and to instruct us, the meeting adjourned.

IVAN E. CARLYLE, M. D., *Secretary.*

LAKE COUNTY MEDICAL SOCIETY

The Lake County Medical Society met in regular session at Mercy Hospital, Gary, Thursday, October 12, 1933, President Jones presiding.

The matter of official recognition of the Calumet Township Medical Society, a group of physicians of that township, all of whom are regular members of the Lake County Medical Society, having been properly referred to the Council, which opined that such recognition could not legally be had under our Constitution, was presented; the chair announced that while the parent society would lend moral support to all laudable undertakings of this township group, official recognition could not be had.

The resolution presented by the Calumet Township Medical Society at the September meeting, proposing some changes in our Constitution and By-Laws, was presented for action. Dr. Wharton suggested that inasmuch as the Council had considered the matter and recommended same be not adopted, that the matter be laid on the table, and made a motion to that effect. The motion was lost. Dr. Schaible then moved the adoption of the resolution, vote on same being had by ballot. Tellers were appointed and reported the ballot as follows: yeas, 22; nays, 32. The chair declared the motion lost.

Dr. E. S. Olson, Gary, was unanimously elected to membership, by transfer.

Nominations for officers, same to be voted on at the December meeting, were announced.

Dr. Pugh then arose to make a statement regarding a member of our Council who has for some time been unable to attend to these duties, on account of illness; he referred to Dr. William D. Weis, of Munster, a former President of our society.

Due to past services rendered to the society and to his present physical condition, Dr. Pugh moved that Dr. Weis be elected to life membership in the society and that a successor be named to his council post. The motion was unanimously adopted.

The scientific program was then entered upon, the chair presenting James G. Garr, of the Medical Department of Northwestern Medical School, who discussed some heart problems. For the most part, Dr. Carr limited his discussion to the therapy of digitalis and certain of the quinine derivatives.

The speaker, long a favorite with our folks, gave us the latest interpretations of the action of these drugs and his talk was received with the most rapt attention. At the conclusion of his presentation Dr. Carr was kept busy for a half hour or so in answering the many questions put to him by an interested audience.

Adjourned.

E. S. JONES, *President.*
E. M. SHANKLIN, *Secretary.*

WOMAN'S AUXILIARY

The Woman's Auxiliary to the Indiana State Medical Association held its annual Breakfast Meeting September 26, 1933, at the French Lick Springs Hotel, French Lick, with Mrs. Charles F. Voyles, president, presiding.

After the invocation by Mrs. R. E. Baker, an address of welcome was given by Mrs. George R. Dillinger.

Dr. E. E. Padgett, president-elect of the State Medical Association, in his greetings to the Auxiliary, voiced his belief in a better and brighter future for all of us. His advice to us was: "Stick to the doctors, and they will pull you through, or you may help them out."

Reports were read by recording secretary, Mrs. R. L. Compton; treasurer, Mrs. U. G. Poland; and corresponding secretary, Mrs. C. N. Combs. These were accepted as read. Three hundred sixty-six members were reported; a bank balance of $274.75 was reported.

Mrs. Edmund D. Clark, chairman of Public Relations, reported six County Auxiliaries with Public Relations Chairmen, speakers on health matters, and satisfactory results.

Mrs. James C. Carter, chairman of Press and Publicity, urged all Auxiliaries over the State to send news items for publication in THE JOURNAL. We were asked also to send material for our State Scrap Book.

Mrs. E. E. Padgett, chairman of Legislation, reported the following important matters which concern the medical profession directly, and to which we lend our moral support: Of national interest—(a) Veterans' and National Economy Act; (b) Right of physicians to prescribe medicinal liquors; and (c) National Recovery Act. (No code yet formed applying to doctors, nurses or hospitals.) Of State interest—The new "set up" of the State Board of Health.

Mrs. J. H. Weinstein, chairman of Organization, reported one new Auxiliary in our State, that being Orange County, our hostess organization at this convention, organized May 10, 1933, with nine members.

Reports read by County Auxiliary presidents revealed interest and enthusiasm in said organizations. Educational, philanthropic and social activities were reported. There have been guest meetings, when speakers were provided, musical programs, a playlet, dinners and teas. Hospital garments and dressings have been made by one organization, while another sewed for the Red Cross. Donations of money to Community Funds, and *Hygeia* subscriptions to public organizations have been given. A "call board" was installed in an Assembly Room, for the convenience of the doctors attending Medical Society meetings. One organization acted as patronesses for the concert given by a nurses' chorus, and responded to the call to assist the Board of "The Birth Control League" in interesting the public in a lecture on that topic. Draperies were furnished for the Infirmary at the Boy Scout Reservation. The dedication of a twenty ton boulder, unveiling of a bronze tablet (presented by the Woman's Auxiliary to the Indianapolis Medical Society) and, with the cooperation of the City Park Board, the landscaping of the grounds surrounding the City Hospital, and a planted avenue of elm trees between the City and Riley Hospitals, as a memorial to the physicians of that place, has attracted attention and been given honorable mention in our own State, and has received national recognition as an outstanding and worthy project.

A report on the national convention at Milwaukee was given by Mrs. R. L. Compton.

Dr. J. H. Weinstein, president of the State Medical Association, explained to the Auxiliary, in his address, the set-up of the State Board of Health. In this explanation, Dr. Weinstein quoted the late Mrs. Walter Jackson Freeman, in her interpretation of preventive medicine as "That which builds a wall at the top of the precipice, instead of placing an ambulance at the bottom." "The present set-up of the State Board of Health," Dr. Weinstein says, "is building that wall." It was further explained as an Educational Program, to educate the public about how to care for themselves—to educate the teachers what to teach, of health, in schools—to educate parents and expected parents to care for their babies in the home, and the necessity of seeing physicians to keep in good condition, by regular health examinations. "This is a real opportunity for local medical societies," said Dr. Weinstein, "since the education of public health is up to the physicians." The State Board of Health must do the work for the indigent—that which they are designated to do—but not as was previously done. The present set-up greatly reduces the expense to the State, and places the Health Educational Program of the State where it justly belongs, in the hands of the Medical Societies, with the guidance of the coordinating committee, composed of representatives of the Indiana State Medical Association, Indiana State Dental Association, Indiana University School of Medicine, Red Cross, Nursing Association, etc., which meets once a month and lays out a program for preventive medicine.

Dr. Weinstein highly complimented the Auxiliary reports and accomplishments. "Such organizations," he said, "spur us on to do better."

Mrs. Voyles suggested that we invite the Advisory Council to breakfast with us next year, that they might know more of our organization and its activities. Mrs. C. N. Combs,

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chairman Nominating Committee, presented the following slate: Mrs. Edmund D. Clark, Indianapolis, president-elect; Mrs. Randolph L. Compton, Osgood, vice-president; Mrs. Fred Wishard, Anderson, recording secretary; Mrs. Frank Gastineau, Indianapolis, corresponding secretary; Mrs. U. G. Poland, Muncie, treasurer. The slate was unanimously accepted, and the new officers were formally introduced.

Mrs. I. N. Trent, incoming president, was called upon for remarks, and responded graciously by expressing her willingness to "act as stage manager, direct the play, shift the scenes, and start the orchestra," for which in return she asks our cooperation. Mrs. Trent commented upon the reports of the Committee on Public Health, and asked that we donate time and study to it during the coming year, and she also wished to stress organization.

A telegram, bearing greetings and good wishes, was received from Mrs. James Blake, National President.

A rising vote of thanks was extended to our hostess Auxiliary (Orange County) in appreciation for the splendid entertainment provided us; also to our speakers, and especially to Mrs. Voyles, our president, for filling an unexpired term, and directing our course through smooth waters, into the port "Successful 1933."

MRS. R. L. COMPTON, Recording Secretary.

ABSTRACTS

AUTOPSY PROBLEM: ITS SOLUTION IN SMALLER COMMUNITIES

GEORGE W. COVEY, Lincoln, Neb. (*Journal A. M. A.*, Oct. 14, 1933), discusses the means by which a moderate sized city, without a medical school, can overcome the obstacles of not having a laboratory for the performing of necropsies. The method principally consists of sharing the expense for the maintenance of such a laboratory by the city hospitals. The author states that Lincoln physicians have by the method outlined developed such an interest in necropsies that over a period of fifty-three months they have done 657 necropsies with complete records, examined and recorded the histopathologic observations, and properly correlated the clinical and pathologic observations in a large number of them as a staff function of the hospitals. This constitutes a necropsy percentage of 15.5 on all deaths in the city for this period, which is over eight times the general average in the United States. The author concludes that there is great need of increasing the number of well done and well studied necropsies, especially in the smaller communities. To do this the medical profession must be made necropsy conscious and the necropsy must be made interesting and profitable to the physician. The cooperation of the mortician is necessary; it can be had and it is invaluable. A plan such as the one adopted in Lincoln is workable and could be adapted to almost any community.

EPIDEMIOLOGY OF LOBAR PNEUMONIA: STUDY OF PREVALENCE OF SPECIFIC STRAINS OF PNEUMOCOCCI IN NASOPHARYNX OF IMMEDIATE FAMILY CONTACTS

WILSON G. SMILLIE, Boston (*Journal A. M. A.*, Oct. 21, 1933), states that, in a study of more than a thousand persons, type I and II pneumococci were found to be much more prevalent in the nasopharynx in immediate family contacts of cases of lobar pneumonia due to the homologous type than in the population at large. The higher types of pneumococci—types III to XIX, inclusive—were just as prevalent in the throat in the general population as in the family contacts of cases of pneumonia due to these specific types. The types most frequently encountered were III, VI and XVIII. The whole group of pneumococci was less prevalent in the late summer months than in the winter and early spring. No one type of pneumococcus showed any deviation from the general rule in seasonal distribution. Poor economic conditions, with resultant overcrowding, did not alone increase the prevalence of any one specific type of pneumococci in contacts of pneumonia due to the homologous type. The studies suggest that epidemics of family colds have some relationship to the prevalence of homologous types of pneumococci in contacts of lobar pneumonia due to type I and II.

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ORIGINAL ARTICLES

CONSIDERATIONS IN THE MANAGEMENT OF FUNCTIONAL DISORDERS OF MENSTRUATION*

N. K. FORSTER, M. D.
HAMMOND

Few discoveries in medical science have so profoundly affected the clinical practice of the general practitioner or gynecologist as have the recent developments regarding the physiologic mechanism associated with the reproductive function in the female. Although this paper is limited to functional disorders of menstruation, yet menstruation itself is so intimately associated with the reproductive process that for clinical purposes it may be regarded as a part of it.

Disturbances of menstruation coming under the classification of functional have been shown to be dependent on hormonal dysfunctioning. For centuries abnormal menstruation has been directly associated with uterine pathology. Various theories have been put forward to explain it, such as chronic endometritis, hyperplasia of the endometrium, fibrosis of the endometrium, etc. It is now, however, almost universally accepted that the cause of abnormal functional menstruation lies outside the uterus and is but the expression of deranged hormonal activities. Moreover it has been demonstrated that menstruation is independent of ovulation, although for a long time it was believed that both were inseparably connected. Animal studies have shown that menstruation occurs without ovulation. The endometrial proliferation normally characteristic of the premenstrual period is not necessary to bleeding, nor is bleeding of fundamental importance in the human sexual cycle. Control of ovulation appears to lie in the pituitary gland, and secondary ovarian changes dependent on special activity of the pituitary produce the changes in the uterine mucosa and increased blood congestion. The function of normal menstruation is a consequence of this under certain conditions.

Before considering menstrual disorders it is not out of place to glance first at the mechanism of normal menstruation according to present-day knowledge.

NORMAL MENSTRUATION

Normal menstruation must be conceived as part of a cyclic hormonal activity of the sex apparatus in the female. According to our present knowledge this cyclic activity is brought about by four essential hormones, two of which are produced in the ovary and are dependent upon two other governing sex hormones produced in the anterior lobe of the pituitary gland. The stimulatory hormones produced in the pituitary are known as prolan A and prolan B. They are of prime importance as direct stimulators of the ovary in the sex cycle, and it is through them, apparently, that the functional activity of the ovary in the reproductive cycle—and, incidentally, of menstruation when pregnancy does not occur—is initiated.

Prolan A stimulates the ovary to ripen and maturate the graafian follicle and to produce, in the fluid in the graafian follicle, the so-called female sex or estrus-producing hormone, also known as estrin, folliculin, or theelin. Prolan B directly stimulates the maturing graafian follicle in its varying stages so that it is transformed into corpus luteum; it also stimulates the corpus luteum to the production of another hormone known as progestin.

We have, therefore, the four specifically acting hormones: prolan A, produced by the anterior pituitary lobe, directly stimulating the follicle before its rupture to the production of the hormone estrin or folliculin; and prolan B, also produced by the anterior pituitary lobe, directly stimulating the production of the hormone progestin by the ripened corpus luteum.

The influence of estrin extends over the proliferative phase of endometrial growth, that is, the period between the onset of the menstrual flow to about the mid-interval space (the time of ovulation). It is an excitant not alone of the uterus but of the entire tubular tract—the fallopian tubes, uterus, and vagina; it brings about not only uterine hyperemia but also hyperemia of the entire genital tract; it is responsible for the early proliferative, non-secretory phases of the endometrium and prepares the way for the secretory premenstrual changes which can occur only in the presence of the corpus luteum.

Progestin, the hormone produced by the corpus luteum, is concerned chiefly with the secretory

* Presented before the Section on Surgery of the Indiana State Medical Association at French Lick, September 27, 1933.

phases of the endometrium, with the growth of the decidua and, when the ovum is fertilized, with the maintenance of pregnancy and the prevention of a fresh ovulation. Progestin cannot, however, do its special work unless the endometrium is first primed by estrin.

We might put the matter in another way and say that estrin is responsible for the elementary structural changes, such as hyperplasia of the endometrium, that are necessary if pregnancy might occur; progestin is responsible for the changes necessary for nidation and nourishment of the fertilized ovum and the inhibition of further ovulation until the pregnancy has been terminated.

If the ovum is not impregnated and pregnancy does not take the place, the corpus luteum undergoes regression with exfoliation of the prepared superficial layers of the endometrium. This shedding of the endometrium and discharge of the engorged blood is what is known as normal menstruation. It is what the old physiologists used to call the result of the "death of a blasted ovum." Strictly it is not a part of the sexual cycle, but a necessary result of it. When the discharge has ceased prolan A again begins to act and the process is repeated with rupture of another follicle on about the twelfth or fourteenth day of the intermediate menstrual period.

Disordered Menstruation

We are now in a better position to understand menstrual irregularities as functional disturbances rather than, as formerly believed, being organic in origin. If any one or more of the essential hormones involved in the cyclic sexual activity is deficient or excessive, no matter what may be the cause, there is likely to be a functional menstrual disorder, that is to say, in irregular menstruation the bleeding is due to some disturbance in the rhythm of pituitary hormonal functioning which affects the estrin or progestin production in the ovary. We are now speaking of periodic, but disturbed, menstrual bleeding and, of course, do not include any metrorrhagias due to pathologic conditions in the uterus or ovary.

The majority of functional menstrual disorders can be ascribed to excessive or prolonged estrin stimulation, but diminished or absent corpus luteum activity may be a charactertistic feature. Follicular cysts in the ovary represent an abnormal persistence of the ripening follicle in which the ovum continues to live, but ovulation does not take place. Clinical and experimental evidence points to the ovarian changes being due to some alteration in the functioning of the pituitary gland.

The most commonly met types of irregular functional menstrual bleeding are amenorrhea, menorrhagia, and dysmenorrhea. These may be seen at any age from puberty to the menopause, but appear to be most common in the fifth decade.

Primary functional amenorrhea is comparatively rare. Since the continuous presence of the corpus luteum hormone, progestin is, according to Allen,[1] responsible for the amenorrhea of pregnancy; it may, perhaps, be assumed that this cause is also operative in many cases of non-pregnancy amenorrhea. Another cause might be deficiency in production of prolan A and a consequent failure in production of estrin.

According to Keene,[2] who studied 394 cases of irregular functional menstrual bleeding, the age incidence is as follows:

Less than 20 years old, 5 per cent.
From 20 to 30 years old, 22 per cent.
From 30 to 40 years old, 25 per cent.
From 40 to 50 years old, 40 per cent.
From 50 to 60 years old, 8 per cent.

The types of bleeding observed was menorrhagic in 38 per cent and metrorrhagic in 62 per cent. In the menorrhagic type the menstrual period was prolonged or shortened almost twice as often as it was normal. In the metrorrhagic type totally irregular bleeding was observed most frequently. Progressive menorrhagia turned into metrorrhagia and occasionally an amenorrhea was followed by continuous bleeding. In a large group the periods exhibited no semblance of regularity, either in their appearance, duration, or in the amount of bleeding, and many of these patients gave a history of irregular menstruation since puberty.

Menorrhagia

The term functional menorrhagia is commonly, though loosely, applied to the various types of excessive menstrual bleeding that are not attributable to tangible pathology of the uterus or adnexa. It may or may not be associated with normal or abnormal periods. Menorrhagia is usually accompanied by hyperplasia of both the epithelial and stromal elements of the uterine mucosa, which is usually found only during the reproductive period. Menorrhagia is clinically more important than other menstrual disorders. The majority of these cases may be considered as due to excessive or prolonged estrin activity or to diminished or absent progestin activity. According to Novak[3] periodic hemorrhage from the genital canal may be of various types, each with an entirely different mechanism. The most common variety, as already mentioned, is functional bleeding with hyperplasia of the endometrium and is, apparently, due to a persistence and excess of the estrin secretion with deficiency or excess of the corpus luteum hormone progestin, both no doubt being due to pituitary imbalance. Witherspoon[4] also considers that the endometrial hyperplasia is due to excess estrin production. Both Cannon[5] and Waters and Williams[6] consider that menorrhagia may often be associated with irregular thyroid gland functioning, that the hyperemic effect of the estrin hormone is augmented by the activity of the thyroid during the premenstrual phase. Should this activity be increased there will be menorrhagia. Although the correlation of the thyroid with the

pituitary and other glands is only imperfectly known, yet it seems probable enough that the pituitary hormonic activity might be affected by the thyroid. This of course directs our attention to the necessity of having a basal metabolic rate on all cases exhibiting menstrual disorders, and it is our opinion that better results in general have been secured through the judicious use of thyroid extract than can be secured through replacement or substitution therapy with theelin or the luteinizing hormone.

DYSMENORRHEA

The colicky, spasmodic pain accompanying menstruation, clinically known as dysmenorrhea, is due most probably to abnormal uterine muscle contractions. It begins a day or two before menstruation. Dysmenorrhea is believed by Witherspoon[4] and others to be due to prolongation of the estrin hormone activity which is characterized by uterine muscle stimulation. Novak and Reynolds[7] also believe that the immediate cause of dysmenorrhea is the exaggerated and painful contraction of the irritated uterine muscle in which the anterior lobe hormone plays an important part. The biologic antidote would seem to be progestin or a substance containing prolan B. Estrin is present in large quantities in the immediate premenstrual period. The inhibitory influence of progestin on uterine muscular activity is removed a day or two before the menstrual onset (it is only prolonged when the ovum is fertilized), and, in some women, this produces dysmenorrhea, especially in those predisposed by constitutional and other factors.

The metrorrhagias belong more to the premenopausal epoch than to that of adolescent menstruation, and there are so many associated conditions to be reckoned with that I do not wish to do more than mention them here. Suffice it to say that the dysfunction is more usually ovarian and that the bleeding is generally independent of the sexual cycle. The underlying condition is more usually organic than functional, and in the great majority of cases some pathologic condition of the ovary will be found as well as the absence of corpora lutea.

HORMONAL DYSFUNCTION TESTS

From the purely clinical standpoint one of the most important considerations is the possibility of determining, in a case of disordered menstruation, whether the functional disability is in the pituitary gland or in the ovary. There are certain tests, such as the Frank and Goldberger tests, for estimating the presence and amount of pituitary hormones in the same fluids. Normally menstruating women do not secrete prolan A in the urine. If it is present it indicates that the anterior pituitary is functioning but the ovary is faulty. The presence of estrin in the urine implies a functioning anterior pituitary, but when the follicular apparatus of the ovary ceases to function the estrin is no longer utilized by the ovaries and is excreted in the urine. According to the presence, absence, or diminished amounts of these hormones in the blood and urine, and the findings on examination of the uterine mucosa, we should be able to arrive at a fair estimate of the functional deficiencies. The tests are delicate and the special technic scarcely comes within the province of the general practitioner; however, up to the present these are the only methods devised for discovering the conditions. Kurzrok,[8] who studied 300 cases, found the tests, as well as the hormone medication based upon them, satisfactory. On the other hand, a critical review by a Council of the American Medical Association[9] states that the work of Frank and others has demonstrated that the clinical picture in menstruation and associated disorders furnishes little or no definite indications as to the quantity present in blood and urine of the particular endocrine factors involved in the normal sexual cycle. These factors vary greatly in normal and pathologic conditions.

TREATMENT OF MENSTRUAL DISORDERS

Menstrual disorders being, as shown, the result of hormonal dysfunctions, the logical therapy should be hormonal substitution, but, as pointed out in the report to the American Medical Association,[9] until the concentration of the special hormones in the blood and tissues, the sensitiveness of the tissues to them, the rates of excretion, etc., are better understood, endocrine therapy will remain a hit or miss procedure and attempts at replacement therapy have generally failed. In any case only estrin and the luteinizing hormone of the pituitary are yet available as commercial preparations. Nevertheless, there are already numerous reports in the literature showing the efficacy of hormonal treatment.

Witherspoon,[4] Novak and Hurd,[10] and Anspach and Hoffman[11] report on the value of the luteinizing hormone of the pituitary. Witherspoon states that in 12 cases of amenorrhea the flow was restored definitely in 6; in 8 cases of idiopathic functional uterine bleeding the hemorrhage was successfully checked. Novak and Hurd report excellent results in 51 cases of functional uterine bleeding; in all but 7 cases the bleeding was checked in a short time. The luteinizing principle obtained from the urine of pregnant women was demonstrated to be a powerful inhibitor of the rhythmic contractility of the uterine muscle. Anspach and Hoffman found the luteinizing hormone successful in all but one of 40 cases of irregular menstrual bleeding in which it was tried; however, in amenorrhea it gave only one successful result in 10 cases.

Hamblen's[12] clinical experience with estrin and anterior pituitary hormones shows that in amenorrhea only 8 out of 28 cases treated could be interpreted as successful re-establishment of menstruation. In 46 patients with oligomenorrhea and hypomenorrhea, 42 obtained excellent regulation of

menstruation. Of 13 patients with dysmenorrhea 11 obtained relief. The author's experience with hypermenorrhea does not warrant any worth-while inferences. Estrin has not proved of value, but the luteinizing hormone yielded satisfactory results in some cases.

Fellner,[13] after 16 years' experience with estrin, states that the results are favorable in certain groups of cases, but in most cases it has failed to give the desired clinical cures.

Stragnell[14] reports that with a special preparation of the follicular hormone there were positive results in 83 per cent of 230 cases of amenorrhea, in 89 per cent of 9 cases of premature menopause, in 92 per cent of 40 cases of dysmenorrhea, and in 4 cases of metrorrhagia. These high percentages have not been approached or confirmed by any other investigator.

Hall[15] reports that in 200 cases of menstrual disorders no untoward reactions have followed a very wide range of dosage (25 to 16,000 rat units) of estrin (follicular hormone). Small divided doses frequently bring about a physiologic healthy condition in amenorrhea, dysmenorrhea, and menopausal conditions.

Mazer and Goldstein[16] believe that estrogenic substance in adequate dosage is useful in the treatment of certain cases of genital hypoplasia of not too long standing, in selected cases of amenorrhea and primary dysmenorrhea, and for the relief of the vasomotor disturbances of the menopause; however, the results are not absolutely convincing. These authors say that in the light of present-day evidence the anterior pituitary-like, and the corpus luteum preparations appear to offer more promise of therapeutic influence than the estrogenic preparations. Estrogenic substances used in large doses for a long time produce sclerosis of the ovaries.

Frank,[17] after 25 years' work, states that estrogenic substances have given no therapeutic results.

Citations of other clinical reports on the value of hormonal treatment in the various disorders of menstruation, as well as other aspects of the whole subject, must necessarily be omitted. It is impossible in a discussion of this nature to take up more than a few of the essential considerations since, in its present stage, one cannot help becoming hopelessly confused by the multiplicity of reports in the past few years, and it seems manifestly impossible for any one person to be fully advised on all of the recent research bearing on the problem of the sex hormones and their actions and effects. In the presence of such a maze of conjectures and discussions and conflicting reports one is led to the conclusion that much worthless therapy is being urged by optimistic, but commercially-minded, dispensers of glandular products upon a hopeful and credulous profession.

Our own experience with these substances certainly does not indicate their specificity in functional menstrual disturbances, nor have the results, in our series of cases studied at the Chicago Lying-In Hospital, been such as to warrant any enthusiasm for replacement therapy, as it is today, in the treatment of these cases.

Of 21 cases of secondary amenorrhea, of what we considered the functional type, only one case showed any result which we felt might be ascribed to the use of the hormones.

Of 32 cases of oligomenorrhea or hypomenorrhea, 3 showed improvement in the menstrual flow under replacement management. This type of case, as well as a number of the amenorrhea cases, was frequently associated with a low basal metabolic rate, and under thyroid management marked improvement was noted in almost 80 per cent of them.

In dysmenorrhea, not associated with any organic pelvic disease, 6 cases were treated with the luteinizing principle with definite improvement in 2 cases.

Menorrhagic cases were studied in 43 instances. Seven apparently were benefited in varying degrees, only one permanently.

In cases of metrorrhagia we were unable to secure any cases not associated with definite pelvic pathology. However, the luteinizing principle was used in a series of 10 of these cases without benefit.

In premenopausal and menopausal cases, whether surgical or natural, the best results were secured. Thirty-five such cases were studied. Of these 7 were premenopausal, and under injections of theelin 4 resumed normal periods but relapsed when treatment was discontinued. Of the 18 natural menopausal cases 15 experienced symptomatic relief, whether theelin or the luteinizing hormone was used. This is not surprising in view of the fact that these cases frequently improve on corpus luteum or ovarian extract, either by mouth or hypodermically, as well as with various medications, and the psychic element cannot be overlooked. Of the 10 surgical menopausal instances, 4 apparently received symptomatic relief under treatment with the luteinizing factor.

In 3 cases of hypoplasia of the genitals, we were unable to determine that any results had been secured through the use of the estrogenic hormone.

In 5 instances of sterility, with no demonstrable pelvic pathology, the administration of theelin had no appreciable effect. However, in one case, in which hebin was used, a normal pregnancy followed the initial production of rather large cystic ovaries.

Figures such as these cannot be considered as a true index of the value or usefulness of this form of therapy. So many factors must necessarily enter into consideration, as already pointed out, such as the dosage, the interval between doses, the duration of the treatments, the sensitiveness of the patient, rate and amount of excretion, time of the cycle at which given, and many other elements of control, that not all of them can possibly be satisfied with our present knowledge. They do indicate, however, that as replacement

therapy exists today there is much to be desired in dealing with these functional disturbances. A great deal of work is being done, and it is entirely reasonable to see in the near future the welding together of many disorganized findings and the discovery of many missing links in this chain of endocrine dysfunction.

Suffice it to say, in conclusion, that while our knowledge of the pathogenesis and etiology of the various conditions coming under the head of disordered menstruation has been enormously increased by recent endocrine studies, therapeutic application of this knowledge is still greatly in need of further clarification and standardization. Clinically, practitioners are still in a fog, but no doubt the mists will be cleared away in time. Endocrinology here, as in other endocrine disorders, needs thorough research, not only as regards the methods of administration but of adequate and effective dosage, as well as proper, easily executed diagnostic test methods.

In any case, enthusiasm for hormonal therapy, until it is definitely and rigorously proved to be thoroughly effective, should not cause the neglect of other effective therapy in functional menstrual disorders.

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DISCUSSION

S. P. HOFFMAN, M. D. (Ft. Wayne): Dr. Forster has written a very excellent paper covering the field according to the latest scientific information which we have on this subject. There is possibly no field that is going to play as important a part in the future of medicine as the field of endocrinology, and while as doctors we know little about this subject, and what we think we know is very vague, I believe the time is near when we will be able to isolate the more commonly known hormones, preserve them properly, and reintroduce them into the human body with some assurance of desirable effects. One hesitates to give personal experiences, and yet it is those personal experiences which must be used in statistics which could not be compiled to any great extent if we were to keep them as secrets. The illustration is this: A short time ago a young girl was brought to me who was just about to enter puberty. She was nervous and difficult to manage and was becoming incorrigible, not in a sexual way but in all other ways. I really did not know of anything to do, and as I studied the case I thought it would be best to get this girl into the menstrual period. With this new phase of life accomplished I thought something might be done, so I selected the best therapeutic agent I could find at the time and began to give her injections in an amount which I hesitated to give to a girl around fifteen years old. The only treatment I gave her was to treat her hypodermically with injections of a preparation which was on the market. I was surprised to find that this treatment accomplished the results I had desired. The girl started menstrual periods earlier possibly than she would have done had I not stimulated her. She is in school now regularly and is a healthy child. I mention this experience at this time for what it may be worth.

F. C. WALKER, M. D. (Indianapolis): There is no question about these menstrual cases being troublesome, especially cases of abnormal bleeding, and particularly in young women. I have a number of these patients now, between seventeen and twenty-five years old, in which the bleeding cannot be accounted for by any organic trouble present, and in many of them I cannot find a thing wrong from that standpoint. These young women present themselves with a great deal of fear—fear that the worst has happened; even young women come to me with the fear that it is cancer, and of course among young women of that age it is very seldom cancer. I think we are on the right road in the solution of this problem because we are now getting down to the essential principles of finding out the chemistry of it. We know that the method of cure will be a chemical one. This whole process is a chemical process and the cure for these menstrual cases will be by interpretation of the chemistry of the matter. A great difficulty is that we find no two women exactly alike. We may treat one woman in a certain way and have good results, but the same treatment

will not help or cure another. I am sure all of you have had this experience.

There are different methods of treatment for this bleeding in young women. Curettage is recommended and has been done for a long time and is curative, but curettage for hyperplastic endometritis does not hit the point except for a short time, and you are kept busy curetting them with no permanent cure; thus you are quite sure in your genital practice that curettage does not go very far. Yet since that is a present help you give curettage a chance for it cannot do much harm and may cure your patient. With some of these young girls I have not used curettage, but with others, but only a few of them, I have used that method but have never been able to cure them. I have held them off until certain things have brought about chemical reaction. In the last two years I have treated twenty-one cases of bleeding in young women below twenty-five years of age and by the use of the ordinary methods we have today, with injections hypodermically, I have been able to control the bleeding in seventeen of these cases. The others did not seem to be benefitted in any marked degree. I believe, however, that when the chemistry of this process is more completely understood and the exact chemical is available, an instrument will be put in our hands with which we may help control a very large number of these cases.

H. L. MILLER, M. D. (West Baden): This matter of hormonal dysfunctioning has been a troublesome one and I have given it much study. If there be normal growth and normal activity of the parts there will be normal functioning, but if they are abnormal there is one of two things the matter. There is something there that should be lacking, or the human body lacks something. That I find true of these ladies that come to me, and ordinarily it appears that there is something lacking in hormonal action, or chemical action, and no operation will help.

N. K. FORSTER, M. D. (Hammond), closing: I want to express my appreciation to the discussants for their kindness in bringing out some very instructive and interesting points in line with the various problems which I have attempted to set forth. I think one thing especially was good, and that is the looking at the individual as a particular case, and not as one of a group of cases to be treated in a general sort of way. I think this is particularly true in those cases where there are no unusual findings of pelvic pathology. I refer, of course, to the fact that this alone does not place the case in the category of those purely functional disorders. Constitutional disorders may be overlooked, malnutrition, secondary anemias and chronic debilitating diseases have to be considered, and certainly if the general condition of the patient is investigated, some of these factors may be brought out, and influence the diagnosis and management to a large extent.

INFECTION IN THE PETROUS PYRAMID*

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Petrositis, or suppuration of the petrous pyramid of the temporal bone, is a recognized disease entity which is a frequent cause of meningitis or brain abscess. At birth the petrous pyramid is a cartilaginous structure containing the ossified labyrinthine capsule. This cartilage is soon converted into a cancellous marrow forming bone. The pneumatization process which extends from the middle ear to the mastoid bone, the zygoma and squamosa in varying degrees may extend in like manner into the petrous tip. The adult petrous portion of the temporal bone may then be either a complete cancellous bone, a highly pneumatized one, or a combination of the two, the type depending upon the amount of pneumatization occurring in the particular individual. The presence or extent of pneumatization in the petrous tip is directly in proportion to the pneumatization of the mastoid, zygomatic and squamosal areas. Obviously, in any person with large mastoid spaces, petrositis is a possible complication.

TYPES OF PETROSITIS

Two types of petrositis may occur: First, a true osteomyelitis which extends through the marrow-bearing spaces, or by way of vascular channels from the middle ear cavity. It is possible also for this osteomyelitis to occur by extension from a sphenoiditis with necrosis of the body of the sphenoid bone. This type of petrositis has been present in only a small percentage of cases observed at postmortem. In the majority of cases infection extends into the petrous tip through the preformed pneumatic spaces. Suppuration occurs and the retained pus in these air cells produces necrosis of the bony walls, and unless drainage is had through the ear or mastoid, extends into the cranial cavity.

Pneumatization of the petrous tip may occur through any one or all of three different pathways, and any attempt at surgical drainage should be based upon the probable entrance of the infection into the tip. The pathways of pneumatizatic extension into the tip are: First, from the peritubal area above the carotid canal and anterior to the labyrinthine capsule; second, from the attic or upper mastoid area along the upper posterior angle of the pyramid above the labyrinthine capsule; third, from the mastoid or lower tympanic area below and behind the labyrinthine capsule.

Petrositis is a complication of middle ear or mastoid suppuration and may occur without mastoid disease if the extension is from the peritubal area. In the majority of cases, however, surgical mastoiditis is present and precedes the symptoms of disease in the pyramid.

* Read before the Ind. Acad. of Oph. and Otolaryn., December, 1932.

In considering the diagnostic features of petrositis we have, first, an infection in the middle ear and mastoid. Kopetsky recommends that all mastoids found to be extensively pneumatized should have an x-ray of the petrous tip for comparison one with the other, or with later roentgenograms if disturbing symptoms should arise.

Second, any case in which thorough middle ear and mastoid drainage has been done without relief from pus discharge; evidence of low grade sepsis and temperature, or temporary relief and then exacerbation, should be looked upon as one with possible suppuration in the petrous bone.

Third, if suppuration continues in the petrous tip, with bone swelling, there also occurs a swelling of the overlying dura which in this case acts as the periosteum. This dural swelling impinges upon the Gasserian ganglion of the fifth nerve and produces the characteristic "eye pain," a most severe pain in and behind the eye on the involved side. This eye pain once described by a patient is not forgotten and is present in practically all cases. It should be remembered that dural swelling must be present to produce this pain and already intracranial changes are taking place.

Some pain may be present in all three of the trigeminal branches, but is more particularly confined to the first, or ophthalmic, division. Eagleton has shown the explanation of this to be that the ophthalmic fibres of the trigeminal are nearest the petrous bone and more firmly bound down by the dura through which it passes.

Paresis or paralysis of the sixth or abducens nerve, one of the Bezold triad, if present with other symptoms, is significant but is not a reliable guide since it only occurs in a small percentage of cases. The abducens nerve lies more medial than the trigeminal, is not as firmly tied down, and unless the dural swelling is considerable and extends to the extreme tip of the petrous bone, it may not be involved. A continued low grade sepsis is characteristic and any sharp increase with accompanying temperature changes is indicative of extension of the infection into the cranial cavity or into the blood stream.

In addition to the above the x-ray is of fundamental importance in determining the presence of suppuration in the petrous tip cells. It is possible in some cases to determine the part of the tip involved, which information is valuable in planning a surgical attack.

Treatment: The best treatment of course is prevention. It would seem reasonable that thorough ear drainage with a complete exenteration of the entire mastoid area, where a mastoid operation is done, would tend to prevent extension of infection into the petrous cells. A careful follow-up of the mastoid cells extending toward the base of the pyramid and into the squamous and zygomatic area, prevents pus retention and makes spontaneous drainage from the tip cells more certain if they are infected.

Surgical procedures designed for tip drainage are: First, the method of Eagleton, who enters the middle temporal fossa, elevates the dura over the petrous bone, and plunges a hook through the anterior bony wall of the pyramid and provides drainage beneath the dura.

Second, the method devised by Almour, in which a radical mastoid operation is done first, then as much of the anterior part of the external bony canal wall as possible is removed. This brings the upper end of the eustachian tube into view, which is the point of entrance, and permits a drill to be placed at an angle of 11° with the axis of the external ear canal. This position permits entrance to the tip cells with a drill above the carotid canal and anterior to the labyrinthine capsule in any case where pneumatization has taken place from the peritubal area. Unless pneumatization of the tip has occurred in this manner the carotid artery and labyrinth are so close together that one or the other must be injured.

Third, the method popularized by New and others, in which the cell extensions along the upper posterior angle of the pyramid are followed above and behind the labyrinth, using small curettes or drills. It is usually necessary to remove part or all of the tegmen antra to provide direct entrance to the tip, but this procedure is much less mutilating and less dangerous. It is probable that a careful study of individual cases will demonstrate each of these operative procedures to be of value in specific instances.

TREATMENT OF SYPHILIS

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The medical historians tell us that Columbus discovered more than America; he discovered syphilis. Shortly after his return to Europe in 1496 almost all of Europe was infested with a malignant type of this disease. Our interest in this matter lies in the fact that at that time the first worthwhile treatment for syphilis was originated. Treatment at that time consisted in mercury by mouth, mercury by inhalation, mercurial rubs and mercurial baths. From the beginning of the fifteenth century until the year 1912, when Ehrlich first discovered and prepared his drug known as salvarsan, little or no improvement was made in the method and manner of treating syphilis, except for the introduction of the iodides in the year 1835. The next improvement in treating this disease was by the introduction of bismuth into the therapeutic regime, about 1922. It is interesting to note that practically all the treatment for syphilis is based on what we call the heavy metal group, namely, arsenic, bismuth, and mercury.

Arsenical Preparations

Regarding these various drugs: there are five arsenical preparations of importance in use. They

are: salvarsan, neosalvarsan, sulpharsphenamine, silver-salvarsan, and tryparsamide. Original salvarsan is the most efficient therapeutically; however, because of the technical difficulties in preparing it for intravenous use and the large amount of solution required to so prepare it, it is seldom used today. Neo-salvarsan made from old salvarsan, while less efficient per gram than old salvarsan, is much more easily prepared for use, and by increasing the amount given at a dose the same effects can be obtained as with old salvarsan. Therefore, it has become the arsenical drug in most common use in the treatment of syphilis. Sulpharsphenamine is made from neo-arsphenamine by oxidation and the addition of sulphur molecule. In the same dosage it is more toxic than the other drugs, but is far less irritating to the subcutaneous tissues and musculature. Therefore, it can be used in the treatment of babies in which condition it is of prime importance. Babies tolerate this drug better than do adults. Silver-salvarsan when prepared for intravenous use makes a black solution somewhat difficult to administer and is, therefore, seldom used. However, some patients who cannot tolerate any of the other forms of arsenic stand silver-salvarsan very well and this fact accounts for its limited use. Tryparsamide is a pentivalent arsenical compound and has the ability to penetrate the meninges. Its use, therefore, is almost entirely limited to the intravenous treatment of neurosyphilis in which condition it is very efficient.

Bismuth Preparations

Most every drug company of any importance and many of unimportance have placed upon the market their particular pet brand of bismuth for use in the treatment of syphilis. These vary from an aqueous colloidal suspension of the metal to various salts of it suspended in an oil or grease. A good bismuth preparation ranks second to the arsenical preparation as a spirocheticidal agent. In addition to this it has the same power to build up the body's defense mechanism against the disease. The bismuth preparations are almost always given intramuscularly. Mercury preparations like bismuth preparations are numerous. It may be given orally, by inunction, or intramuscularly which is by far the preferable route. It is most commonly used as a salt of the metal suspended in an oil or grease. It is of the least value of the three drugs as a spirocheticidal agent, but does have some value in building up the body's defense mechanism. Its place in treatment has been rapidly superseded by bismuth preparations. It is usually used intramuscularly.

Treatment

Because all of these drugs are potential poisons to the body, none of them can be used continuously in the treatment of syphilis. Furthermore, after a period of use they seem to lose their efficiency as spirocheticidal agents. Therefore, the almost universal practice during treatment is to use these drugs in rotation. The first principal in the treatment of syphilis is to make a definite diagnosis, and the earlier this diagnosis is made the better chance that patient has for a radical cure of the disease. The second principle of treatment is to have a definite objective. There is considerable difference as to how a young boy suffering with acute syphilis and having a life expectancy of 40 to 50 years should be treated as compared to the treatment of an old man with a short life expectancy and suffering with some of the latent lesions of the disease. In speaking of the treatment of the acute form of the disease in a young patient we have three general systems of treatment from which we may choose; first is the continuous method; second is the intermittent method; and, third is the combined method of treatment. I feel that the continuous method is the best and use it almost entirely. It is given as follows: The young adult patient is given, as his first treatment, a small dose of neo-salvarsan, usually 0.3 gram; four days later he is given a 0.45 gram dose; and five days later a 0.6 gram dose which dosage is continued until a total of ten or twelve injections have been given. Following this he is placed on bismuth therapy, given intramuscularly at weekly intervals for a period of from ten to twelve weeks. We may then, if we choose, give him a course of mercury treatments similar to the course given of bismuth, or we may revert directly to the second arsenical course. This plan of giving arsenic, bismuth, and mercury preparations in routine is continued for as long as is thought necessary to protect that patient forever from having a relapse of the disease.

The intermittent method of treatment varies from the continuous method in that at the end of a course of arsenic, bismuth, and mercury treatments the patient is put on a rest period of from four weeks to four months, depending on how he has stood the previous medication. Following the rest period a second course similar to the first is given, and the whole process is repeated as long as is thought necessary to prevent a relapse.

The combined method of treatment varies from the former systems in that the drugs are given in rotation, that is, between each weekly injection of an arsenical preparation, either a bismuth or a mercury treatment is given. This particular type of treatment is of especial value in those patients who are extremely resistant to the arsenical drugs alone. The combined method of treatment will often give a wonderful result when the continuous or intermittent method has failed completely.

As to the minimum length of time required for adequate treatment, a patient who is darkfield positive and serologically negative should have at least one year's continuous treatment. A patient who is darkfield positive and serologically positive should

have one year's continuous treatment after the Wassermann test has become negative. A patient in the early secondaries with positive Wassermann test should have one and one-half years of continuous treatment after he has become Wassermann negative, and a patient who is in the late secondary stage with positive Wassermann should have two years of continuous treatment after the Wassermann test has become negative. It is only by such large amounts of treatment that you can protect the patient against a late relapse of the disease.

In all cases of acute syphilis spinal puncture should be done early in the disease, that is, by the end of the fifth or sixth week of treatment. From 15 to 30% (figures from various clinics) of all syphilitic patients are potential neurosyphilitics. Serological laboratory tests made on a spinal fluid attained as early as the fifth or sixth week of the disease will show positive findings in a very high percentage of this potential neurosyphilitic group. This means we can determine by laboratory means long before there are subjective symptoms or clinical signs, whether or not we are to deal with a case of neurosyphilis. If a patient is found to have evidence of neurosyphilis he should be placed upon tryparsamide therapy at once and treatment continued week after week for about a year, careful attention being paid to his eyes, as tryparsamide is a drug extremely dangerous to the optic nerve.

Now as to the treatment of the older patients suffering with a latent syphilis. These patients should always have their treatment started with a slow acting drug such as mercury or bismuth because there is danger of producing a severe reaction if we start with a rapidly acting drug such as an arsenical. However, following a few injections of bismuth or mercury these patients can be placed upon arsenical treatment given in smaller doses than the aforementioned. The routine of treatment can then be carried out as desired with any one of the methods previously mentioned. Treatment in these older cases is continued so long as improvement is noticed. This may vary from a few months to a few years, the only desire of treatment being to produce a longer and more useful life for that patient.

Conclusions

In summing up the treatment of syphilis there are several principles which may be followed to good advantage. Firstly, the earlier the diagnosis is made the better chance that patient has for a complete eradication of the disease. Secondly, acute syphilis should be treated vigorously and regularly for a long period after the Wassermann test has become negative. Thirdly, latent syphilis should have treatment begun with a midly acting drug and treatment continued regularly for so long as it improves the patient, the desire being not to eradicate the disease, but to give him a longer and more useful life. Lastly, spinal puncture should always be done early in the disease because by that means alone you can determine whether or not neurosyphilis is likely to occur, and if so, can institute treatment for it at a time when it will be of special value to the patient.

ULCERATIVE INTESTINAL TUBERCULOSIS

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It has long been known that clinical diagnosis provides an unsatisfactory basis for the diagnosis of intestinal tuberculosis. Many patients have digestive complaints which by the most modern and thorough methods cannot be proved to be of a tuberculous colitis or enteritis origin; and, conversely, cases with definite intestinal tuberculosis sometimes present no symptoms at all or, at most, very slight ones. Bacilli in the stool are of no significance if the patient has a positive sputum. Carefully conducted tests for occult blood if positive, or a positive leucocytosis in the absence of a cavity to account for it, are each suggestive. The gross character of the stool is of import. The nonfermentative, pasty alcoholic, vicious stool, especially the one containing occult blood, should be looked upon with suspicion. However, the present-day, single, reliable method to prove or disprove the presence of this complication of pulmonary disease is the barium meal roentgenographic study. Of eighty-five cases of pulmonary tuberculosis admitted to Sunnyside Sanatorium, three per cent of the minimal cases, eight per cent of the moderately advanced cases, and twenty-five per cent of the far advanced cases were found to have intestinal tuberculosis. Hence, minimal pulmonary involvement does not exclude intestinal involvement and the farther advanced the pulmonary lesion the greater is the possibility of intestinal complication.

It is assumed that intestinal tuberculosis is the result of the successful deposit and multiplication of the tubercle bacillus within the intestinal wall. The organism is carried to this place from an existing focus either by means of the lymphatics or the blood vessels, or perhaps most often through the alimentary canal by means of swallowed sputum. It is not, however, the purpose of this paper to take up this problem.

X-ray Evidence

There are two factors that govern the appearance of the roentgenologic pictures, i.e., anatomical changes in the intestinal wall, and functional motor disturbances. In the living body the internal changes are not generally visible, but the signs which are due to anatomic changes in the intestinal wall are most important for diagnosis. A contour

* Presented before the Indianapolis Medical Society, February 14, 1933.

with small notches or waves indicates ulcerous tissue. Rigidity of the wall, usually accompanied by obliteration of the haustra, constriction of lumen and defective dilatability, indicates processes of infiltration. Circumscribed absence of shadow, usually in the ascending colon and caecum, is regarded as the sign of lumen constriction from infiltration or like changes in the intestinal wall. Intestinal stenosis is an important sign.

Differential diagnosis is difficult where colitis ulcerosa is concerned, since in the latter ulcerous tissue, defects are present which cause the same roentgenologic changes in contour as are caused by tuberculosis, yet the changes seem to be less extensive.

The x-ray diagnosis of intestinal tuberculosis is made chiefly by the serial plate method, although the fluoroscopic findings have considerable supplementary value.

Two glasses of barium sulphate in malted milk are given in the morning of the first day's study. The usual breakfast may be taken immediately thereafter, after which no further food is allowed until the first picture is taken. Seven hours after ingestion of the barium the first examination takes place and consists of fluoroscopic study of the small bowel, caecum and ascending colon, that is to say, all parts of the intestine containing opaque mixtures at this time. A second examination is usually conducted about thirty minutes later. "Orientation" is the first thing sought for at these fluoroscopic examinations; that is, where is the ileocaecal junction—where is the tip of the caecum?—etc. Next, form and outline are considered, special attention being devoted to the caecum and ascending colon where the positive findings occur more often. If the entire tract looks normal, with the caecum and ascending colon well filled and showing haustral markings throughout, a single 12″ x 14″ film is made, including the ileocaecal region, ascending colon. This terminates the x-ray series except for a twenty-four hour examination the following morning. If the case has suggestive findings, three or four fluoroscopic studies with about the same number of plates are made at about one-half to one hour intervals. At twenty-four hours each case is studied fluoroscopically again and the suspicious cases have a 14″ x 17″ film of the large bowel made.

Although the enema is administered occasionally, it is not considered altogether reliable and a definite positive or negative diagnosis is usually reached without its administration.

Findings in Ulcerative Tuberculous Colitis

a. *Large Bowel*
 1. Absence of filling in part or entirety of caecum and ascending colon.
 2. "Inconstantly constant" filling defect (always present but not with the sameness of carcinoma filling defect), of ascending and transverse colons (spasms).
 3. Abnormal "spotting" or barium retention (thought to be barium in ulcer craters, usually a twenty-four hour finding).
 4. Marked hypermotility (not infrequently the entire meal is expelled at or before the twenty-four hour study).
 5. Of minor importance—(a) seven hour gastric residue, (b) ileocaecal incompetence on enema examination. These findings are not pathognomonic, but are more frequently seen in positive than negative cases.
 6. Enema findings usually verify results of meal.

b. *Small Bowel*
 1. Segmentation (evidence of spasm).
 2. Distention of small bowel loops.

Clinical Evidence

It is a well known fact that in any disease whose average duration is two to five years, digestive disturbances are very likely to occur sooner or later. The cause of this is not difficult to discover. The treatment of pulmonary tuberculosis depends on the internal or vital resources, if we may so term them. The general condition of the patient is looked upon as of paramount importance for recovery. The treatment is very passive. The patient is told to take no exercise, to be in the open and to eat as much as possible. The result of such a method of treatment is that the only form of activity in which patients are allowed any discretion is in eating and the natural result is that many over-eat. Some of these gastric disturbances often develop early in the disease. In fact, some often occur before diagnosis is made and may recur from time to time. The main question, and one hitherto impossible of accurate solution, is whether these gastric disturbances are—(1) functional, i.e., from over-eating (2) due to the toxemia of the tuberculous process outside the gastrointestinal tracts, or (3) to tuberculous involvement of the intestinal tract or (4) to coincidental nontuberculous organic disease of the gastrointestinal tract.

The following resume represents the prevalence of the gastrointestinal disturbances in our three groups of minimal, moderately advanced and far advanced pulmonary tuberculosis, which have been diagnosed by the x-ray to be of positive tuberculous colitis.

Pain. We observe from our data that pain is very frequent in these three groups and can be explained by the increased tone of the bowel muscle. The law of the intestine, i.e., relaxation of a distal before contraction of a proximal portion of an intestinal segment, therefore cannot take place, as the ulcerated segment is often in a state of spasm, or it cannot relax on account of pathological changes. The descending wave of contraction, forcing the intestinal contents (gas or fluid) before it causes such increase of tension or distension that colicky pain results, due to pressure

on the nerves which stenosis, or hypertrophy of the muscle, would increase. It is probable that only when there is abnormal motor activity does pain occur. In absence of diarrhea, obstruction and localized peritonitis or serositis, intestinal ulceration may cause no pain. The pain occurring during or after meals, of which some complain, may be explained by the fact that the consumption of food and its passage through the pylorus and duodenum cause ileal and colonic contractions. A large per cent of this series complained of loss of appetite, disgust for food, nausea at the sight or smell of food, or a feeling of fulness after a few mouthfuls. This may be due to reverse peristalsis.

Furthermore, we have noticed in a few of our cases complaints simulating those of the peptic ulcer symptom complex. Singer and Ortner explain such a symptom complex as being due to a mechanical irritation of the stomach vagus from the hilus region, either from pressure on the vagus and sympathetic nerves by a tuberculous gland, or irritation by diaphragmatic or mediastinal pleurisy. They claim that even small tuberculous foci, when they extend to the mediastinal vegetative nerves, may cause conditions of sensory, motor, secretory, and vaso-motor irritation, which may simulate ulcer symptoms even to the production of hematemesis.

Diarrhea

Diarrhea was another frequent symptom, and it is highly presumptive evidence of tuberculous enteritis when it occurs chronically or repeatedly in a patient known to have pulmonary tuberculosis. We carefully kept in mind the four principal forms of the non-tuberculous diarrhea:

a. Motor diarrhea due to intestinal hyperkinesia and premature evacuation of the caecal or (small) intestinal contents.
b. Fermentative diarrhea (Schmidt).
c. Diarrhea due to digestive insufficiency.
d. Diarrhea due to catarrhal enteritis.

Consequently when diarrhea was a conspicious or leading symptom, we employed all the diagnostic procedure to prove its tuberculous etiology—stool examination for bacilli, blood and x-ray examinations.

We have found that the non-tuberculous cases of diarrhea are usually controlled by ordinary medical measures. On the other hand, those cases of diarrhea which proved refractory to the ordinary dietetic and medical measures, usually were tuberculous.

Laboratory Evidence

Schilling Differential

The blood picture: In our study we employed the Schilling method in following the progress of our cases.

Schilling divides the polymorphonuclears into (1) Mature, multilobed or segmental nuclears of the typical polymorphonuclears; (2) the band formed nucleated polymorphonuclear, Stabkernige or Rod cell (normally 4% but with active infection the number increases); (3) the immature form of polymorphonuclear (juvenile or young cells). He claims that in tuberculosis the differential count presents a definite picture depending on the measure of activity and the degree of sepsis. For an illustration we apply the use of the hemogram:

Hemogram	White Count	Basophiles	Eosinophiles	Neutrophiles					
				Myelocytes	Juveniles	Stabkernige Rod Nuclears	Segmented Nuclears	Lymphocytes	Monocytes
Normal Limits	5–800	0–1%	2–4%	..	..	4	63	23	6
Beginning tbc. with good prognosis	5–800	0–1%	2–4%	..	..	6	60	25	4
Tbc. with bad prognosis (Degenerative Shift)	5000	1		..	..	16	75	8	1
Cbronic tbc. with activity (Regenerative Shift)	5000		1	..	2	8	60	23	5

We observe that:

a. Beginning tuberculosis with good prognosis
 1. Increase of lymphocytes (lymphocytosis).
 2. Slight shift to the left.
 3. Normal eosinophiles.
b. Tuberculosis with bad prognosis.
 1. Regenerative picture.
 2. Lymphopenia.
 3. Hypo-eosinophilia.
 4. Neutrophilic hyperclocytosis with shift to stabs.
c. Chronic tuberculosis with activity.
 1. Increase in stabs and juveniles.
 2. Lymphopenia.

However, a summary of our observation with study at intervals of two weeks is as follows:

1. Cases that showed a healing trend, the total count was usually 6-10,000 (average about 7,500), the polymorphonuclears 60-70%, lymphocytes 25-40%.
2. Actively progressive cases had the tendency for a total leucocyte count to rise with polymorphonuclear increase associated with lymphopenia.
3. A drop in the white count alone was viewed with suspicion when the polymorphonuclears remained elevated and the lymphocytes low; for such a change often means exhaustion of the defensive mechanism before death.
4. We failed to make any deduction as to the eosinophilia or monocytic counts.
5. Ten cases who died a pulmonary death showed a typical degenerative shift, as previously described, a few days before death.
6. Young forms, juveniles, were not constant in the chronic cases with activity.

Blood Sedimentation Tests

Until recently a diagnosis of activity in tuberculosis was based entirely on clinical judgment. In the past few years the sedimentation test has established itself as a very valuable means of estimating activity.

The one c.c. Cutler graphic technique was followed throughout.*

We observed that cases which were clinically inactive showed diagonal line, i.e., quiescence, had a temperature ranging from 97° to 99.6° and a pulse of 78 to 102, at the time the sedimentation test was taken.

The next group which showed diagonal curves, i.e., slightly to moderately active. (Sedimentation time 60 minutes—Sedimentation index 17-20), were clinically moderately active, having a temperature ranging between 97° and 101.4° and a pulse of 96 to 122.

Some of this group always had positive sputum, while others at the time of the test showed negative sputum but previously had had positive tests.

The last group showed vertical line. (Sedimentation time—60 minutes, Sedimentation index 23-35.)

All were bed patients. Two died three months later at the sanatorium. The temperature ranged from 99° to 103°, the pulse from 110 to 130, and sputum was always positive and clinically they were far advanced and active.

In four cases the sedimentation test did not coincide with the clinical picture.

Gastric Analysis

In each case the fasting stomach was emptied of its residuum, which was analyzed chemically and microscopically. Then the test meal was given. This consisted of a shredded wheat biscuit with a glass of water. The contents were withdrawn in exactly an hour after ingestion of the meal, taken to the laboratory, and an immediate analysis followed.

Our results show: 4% achlorhydria; 20% hyposecretion; 46% normal secretion; and 30% hypersecretion. This group included only patients that were in the minimal and moderately advanced stages, none of the bed patients, who were too sick for the procedure.

Blood Chlorides and Blood Calcium

The blood chlorides of this group were 87% above the normal limits. On the other hand, the blood calcium was 75% below normal, ranging from 5 to 8.5 mgm. per 100 c.c. of serum.

This observation was rather interesting, although we recognize that this number is not enough from which to make any dogmatic conclusion. We wondered why, in spite of food rich in calcium, the blood calcium should have the tendency to be below normal. Is the organism at fault physiologically, or does the high blood chloride interfere in such metabolism?

Furthermore, does the credit that is attributed to the Gerson Salt-Free diet go to the vitamins intake (which is abundant in the base forming foods of Gerson's diet) or to the decrease of sodium and chloride ions in the blood, due to such a diet.

PROGNOSIS

The prognosis, according to our statistics, shows that of the cases positively diagnosed by x-ray, 65% made definite improvement under ultraviolet ray plus cod liver oil and tomato juice treatment. The results of such treatment have been studied by subsequent x-ray examinations at intervals of six to ten months. If the case is one that responded well to lamp therapy, the filling defects and evidence of spasm often disappear entirely.

Four cases that came to autopsy (where the patients died of pulmonary tuberculosis) presented evidence of healed intestinal tuberculosis.

* Cutler, J. W. The graphic method for the blood sedimentation test. Presentation of a one cu. cm. technique and other modifications and suggestions, *Amer. Rev. of Tuberculosis*, 1927, V. IX, 544.

THE ABDOMINAL TRIAD

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TERRE HAUTE

Many volumes have been written upon duodenal ulcer, gall-bladder disease, and appendicitis as clinical entities; but the literature has been rather sparse which considered them as a unit. The purpose of this paper, therefore, is to emphasize the importance of integrating the abdominal organs as to their anatomical, physiological, and symptomatological relationship; and also to point out that there are fairly adequate and accurate diagnostic procedures for their clinical separation and diagnosis.

First, it is reasonable to say that since the intestinal tract and its associated organs function together towards one end, i.e., the digestion and assimilation of food, that disease in one part will indirectly affect the others. The relationship, however, goes further than that, as it has been demonstrated[1] that there is a direct lymphatic flow between the first portion of the duodenum and the gall-bladder and conversely, also that the lymphatic drainage from the appendix reaches the glands about the portal vein, which likewise receive the flow from the gall-bladder and duodenum.

Larimore[2] in a study of nearly 5,000 cases examined, found 18% of those with peptic ulcer had previously had an appendectomy, and another 40% showed x-ray evidence of appendiceal pathology. Of the operated cholecystitis cases, 16% had had a previous appendectomy, while another 60% showed a pathological appendix at operation. He also pointed out that ulcer and cholecystitis are much more apt to follow an appendicitis manifesting itself in patients twenty-five or more years of age.

This association of diseases brings up the question as to whether or not the purported failures of operations for chronic appendicitis, usually placed at 40%, are all the result of mistaken diagnoses. In the light of the proven association of appendicitis, cholecystitis, and duodenal ulcer, one must assume that many of them were not mistakes in diagnosis, in so far as the appendix was concerned, but in all probability a failure to make a complete diagnosis.

It is useless to go into an analysis of the symptomatology of this so-called abdominal triad. Everyone is familiar with the classical symptoms associated with each disease, such as pain referred to the shoulder blade, hunger pain, etc.; but these are not always present and are not infallible. Then there is always that large group suffering with attacks of pain in the right epigastrium, nausea, dyspepsia, and constipation that offers many possibilities as to diagnosis.

The following two case histories, given briefly, are presented to illustrate the confusion of symptoms in these conditions:

Case 1. P. S., Housewife. For the past year has suffered from periodic attacks of pain in right upper quadrant, associated with nausea and vomiting. Pain so severe that morphine was required. Palpation of abdomen showed diffuse tenderness throughout right side. Clinical diagnosis, cholecystitis. X-ray examination of stomach negative; appendix visualized extending downward and laterally from cecum, lumen variable in width, containing numerous fecoliths, and the tip adherent to the posterior abdominal wall in the hollow of the ileum. Cholecystography not done in view of patient's financial status and appendiceal findings. Operation revealed a subacutely inflamed appendix, adherent in post-cecal pouch and containing two definite segments of constriction. Gall-bladder normal to palpation.

Case 2. C. E., age 43. For past five years has had attacks of pain in epigastrium with nausea and vomiting. No history of jaundice. Present illness came on suddenly with nausea and vomiting following a normal breakfast. Pain increased in severity, developed temperature after about 24 hours. Admitted to hospital with a tentative diagnosis of gastric ulcer with possible perforation. X-ray examination of stomach negative but films revealed faintly calcified bodies in gall-bladder region. Cholecystography gave no shadow of gall-bladder other than the stones. Patient developed faint jaundice soon after admission. Refused operation.

Here we have two patients with almost identical symptoms; one with a diagnosis of cholecystitis that proved to be subacute appendicitis, and the second labelled ruptured gastric ulcer and proven to be cholelithiasis.

Gastro-intestinal and gall-bladder examinations have been used universally in the last few years. The value of such examinations is not fully appreciated by many men in smaller communities because of poor results obtained. The accuracy and adequacy of these examinations are dependent upon several factors. First, the examination should be made by a trained observer, negative findings especially, in untrained hands mean nothing. It cannot be disputed that ulcers especially in the stomach are not always demonstrable. The probabilities are, however, that examinations for duodenal ulcer by a trained observer are 85 to 95% accurate. The accuracy of cholecystography has been placed by various writers to be between 90 and 97% correct. Examination of the appendix is the least satisfactory of all, but nevertheless is often of very definite value. The appendix can be visualized in about 50% of the cases examined, provided the patient receives barium by mouth, followed by barium enema, and finally a fluoroscopic examination of the cecum several hours afterward. Even though the appendix is not visualized, valuable information may be obtained through finding pathology in the cecum, demonstrating a fixed cecum, or localizing a point of greatest tenderness.

Because of the fact that the diseases of the abdominal triad are confusing in their clinical symptoms, that one or more are frequently involved, and that a diseased gall-bladder cannot always be diagnosed by palpation and appearance at operation, a gastro-intestinal and cholecystographic examination should be done on every patient beyond the age of twenty-five with clinical symptoms of any one of the three conditions.

By way of summary I submit the following conclusions:

1. There is a definite connection between the appendix, gall-bladder, and stomach, both anatomically and pathologically.

2. A continuance or recurrence of symptoms after appendectomy does not necessarily mean the diagnosis was wrong, but rather incomplete.

3. Cholecystography and gastro-intestinal examinations offer a comparatively accurate means of diagnosis, and should be used in conjunction.

4. Before operation for disease in one of the abdominal triad a gastro-intestinal and gall-bladder examination should be made.

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CORRECTION: In the paper by Mr. William Book on page 552 in the November issue of THE JOURNAL, questions credited to Dr. S. P. Hoffman, of Fort Wayne, should have been ascribed to Dr. M. R. Lohman, of Fort Wayne.

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DECEMBER, 1933

EDITORIALS

EVOLUTION COMES OF AGE

Ever since Darwin's "Origin of Species" in 1859 the "theory of evolution" has been the playground of many classes of persons—the biologist, the theologist, the metaphysician, and the person who just wouldn't admit "relationship to any monkey." Many of these opinions are based on arm-chair mental exercises and have added little of importance to the advancement of the real problems of evolution.

A much deserved recognition has just been given to Thomas Hunt Morgan, Ph. D., LL. D., Sc. D., Professor of Biology, California Institute of Technology, in awarding to him the Nobel Prize in Medicine for 1933 in recognition of "discoveries concerning the eugenic function of the chromosomes." This year the award amounts to about $40,000. Dr. Morgan is not without honor among his fellow workers, for he was president of the International Congress of Genetics in 1932, president of the American Association for the Advancement of Science in 1929-30, and president of the National Academy of Sciences from 1927 to 1931.

For thirty years he has been an indefatigable investigator into the secrets of heredity, as judged by his voluminous contributions to the literature. His recent book, "The Scientific Basis of Evolution," deserves to be read by anyone interested in this important subject. In the preface he states: "In biology the time has gone by when the discussion of the problems of evolution is supposed to be a field in which everybody can speculate without respect to the evidence at hand, and more particularly without any regard to the value of the kind of evidence on which an opinion can safely rest. It is, in fact, the main purpose of this book to insist that the study of evolution has become sufficiently advanced to rest our case for its acceptance on the same scientific procedure that has led to the great advances in chemistry and physics."

Due to Dr. Morgan's approach in his work with the chromosomes and his association of genes with them, evolution has come of age and takes its scientific place with physics and chemistry. He has demonstrated that chromosomes are constant in every cell of a given organism and with them the genes which are his own conception of the invisible units of heredity. The gene is to the living cell what the electron is to the atom of inorganic chemistry. Each gene is charged with the transmission of a given characteristic to the next generation.

Organic evolution means that life now on the earth has descended from other life of the past and that in this descent process changes have taken place with the development of higher and more complicated types from lower and simpler types. Dr. Morgan has pointed out that a great number of new and valuable types of animal and plant life have been developed by biologists and that they have been able to live and reproduce because of the protection given to them by men. All forms of life continually produce mutant or change types which, without the protection afforded by an unusually kind dispensation of nature or of men, would rapidly fall by the wayside. Modern medicine has made it possible for a varied class of individuals to live who, under nature in the savage form, would not have stood the hardships of an unprotected life.

Dr. Morgan has demonstrated in the fruit fly and in many other similar forms of life where many generations may be studied in a comparatively short space of time that mutant forms are constantly being developed spontaneously and that with protection new lines may be propagated. He has also shown that by influencing the genes of certain forms of life by x-ray and other chemical or physical stimuli new mutant lines can be developed and made to reproduce.

The practical lesson for medicine is real. Because of the ethical and moral make-up of our present society all human life is protected, no matter how fit or unfit mentally or physically. Undoubtedly many physically weak types otherwise desirable have been preserved for very great usefulness who, under the savage state, would have perished. In domesticated animals and cultivated plants only the highly valuable forms are encouraged or allowed to continue.

Dr. Morgan points out that "It is not improbable that the evolution of the human race will in the future also be carried on under man's direction. If so, one important function of the science of genetics is to see to it that this is not done stupidly and without foresight."

DISAPPOINTED? YES!

A column from the Indianapolis *Times* of October 18, written by David Dietz, science editor of the Scripps-Howard newspapers, is of more than ordinary interest to physicians and holds a special attraction for Indiana physicians. We had thought we were through with the discussion of matters pertaining to the Indiana plan for the time being, but the above mentioned story arouses us to have something to say again concerning the matter in general.

Quoting from the opening statement of the Dietz story: "The Milbank Memorial Fund, which was the chief financial supporter of the Committee on the Costs of Medical Care, expressed disappointment over the final report of that committee in its annual report made public today."

The story then goes on to relate the "extreme regret" of one Mr. John A. Kingsbury, secretary of the Milbank Memorial Fund Foundation, in that "the committee failed to propose a comprehensive program which would solve the basic problem which it uncovered." He makes it plain that it is his opinion that the money invested in the committee survey was well invested because of the mass of information—some of it misinformation—that the program revealed, but he regrets the absence of the recommendation of a definite program by said committee.

He states: "This failure cannot be ascribed wholly to a lack of vision or of courage on the part of all its members; in all fairness it should be said that much of the fault lay with obstructionists' tactics on the part of certain groups of physicians who generally control medical organizations and often are able to use the great prestige of these organizations to prevent, rather than promote, the delivery of adequate medical services to all of the people."

One might infer, without undue cerebral fatigue, that this has a direct reference to officers of the American Medical Association in particular. Such an indictment will not hold water because it is absolutely without merit and is not based on actual fact. It is utter folly to say that organized medicine is seeking to prevent "the delivery of adequate medical services to all of the people!" No other profession, no other group has so consistently fostered the prevention of disease as has the medical profession; what other profession is continually preaching a gospel that, in the end, means a decided restriction of its future field? It is often said that when a layman undertakes the direction of a professional group, or when he essays the "education" of such a group, he sooner or later comes a cropper. Mr. Kingsbury, if he is correctly quoted, comes something worse than a cropper, he becomes a decided FLOP!

A bit further along in the statement Mr. Kingsbury expresses deep regret that the committee failed to establish a solution of the many problems underlying the providing of proper medical care to all of the people; by inference he lays the blame for this to the group of "obstructionists" previously mentioned. He summarizes his findings thus:

"But looking at the history of medicine and public health (keep in mind this hook-up—*Ed.*) in the perspective, such an attitude is not so strange as it appears; *it has characterized the practice of medicine for centuries.*" (Italics ours.)

Now, get this! This broadside from the secretary of the Milbank Foundation, whether by intent or otherwise we do not know, seems to have been just about properly timed; it appeared coincidentally with the annual meeting of the American Public Health Association in Indianapolis.

It may seem that we are doing a liberal bit of quoting, but bear with us while we hand you this one; it's good: "The need for a national health plan is emphasized in the Milbank report." All right, if we need a national health plan then by all the rules of reason do we need a state health plan, and, members of the Indiana profession, that is the very thing that the Indiana plan offers to the people of this sovereign state; it is the selfsame thing that is even now in operation and will continue to operate notwithstanding the sniping tactics of certain individuals, institutions, and organizations to the contrary!

Broad statement, that; yes, but this is no time for mincing words, when a man of supposed authority, a man who by the very nature of his position should and does command the attention and respect of his readers, speaking of the fact that state boards of health, generally, have made cuts of an average of ten per cent in their budgets, follows with this malicious broadside:

"In some states the reduction in appropriation for public health has amounted to 60 per cent. This means that many counties, cities, and even whole states have been obliged to abandon vital health services. This is notably true in the states of Alabama, New Mexico, the Dakotas *and of Indiana, where the State Department of Health has been virtually abandoned.*" (Again, italics ours.) Indiana has abandoned its Department of Health! That is a palpable falsehood; it bears no semblance whatever to truth; furthermore, it can but be regarded as a most malicious falsehood! The author thereby loses all right that he may have heretofore had to be considered an authority on the matters of which he writes. No, Indiana has not abolished its State Board of Health; Indiana has not so reduced her appropriation for health measures as to jeopardize its citizenry; on the other hand, Indiana has placed its health department where it should have been years ago, directly in the hands of its medical profession. True it is that we are spending less money, *by almost one hundred thousand dollars yearly,* but with the Indiana plan we will find that more work has been done and the

health of our people more securely safeguarded than heretofore.

Therefore, we refuse to be alarmed about the disappointments of Mr. Kingsbury.

LABORATORY DIAGNOSIS VERSUS CLINICAL DIAGNOSIS

During the past two decades the laboratory has come forward rapidly as an aid to clinical diagnosis. In a few instances laboratory tests are made on patients even before any other examination. We are delighted to see the increase in efficiency in the laboratories and the increased use of them, but the author of this editorial, himself a laboratory man, is gravely concerned with the possibility that this tendency may lead us into serious difficulties. It is his personal opinion that no diagnosis of any sort can be made by examination of a laboratory specimen, that diagnosis is the function of clinical physicians who actually see the patients, and that no one else under any circumstances should make a decision that a patient has or has not a particular disease. Unless the history of the case and the clinical findings are taken into consideration, there is grave danger of a mistake being made.

It is always possible that the specimen which is sent to the laboratory was not collected correctly; that it may have been exchanged for another specimen—either before or after it reached the laboratory; that the laboratory technician may have made an error; and that some mistake was made in reporting, or in the interpretation of the report. For example, there are other acid fast bacilli besides the tubercle bacilli; there are other things which will reduce copper solutions besides sugar in the urine; there are other conditions that will give positive "A-1" Widal besides typhoid fever.

In insisting upon this point, we have sometimes not been able to make ourselves clear to those who have seen fit to differ with us. The point is essentially that it is fundamentally wrong when one is seeking to build a building, to secure a well-rounded education, or to make an accurate diagnosis, to begin at the top. The patient who finds himself ill should go first to his family physician and not to a specialist. After a thorough examination by a general practitioner he is then ready to go to the specialist if such an examination seems to be indicated. Likewise, after consideration of the history and the clinical signs and symptoms, and not until then, the physician is ready to recommend special tests of various sorts. We believe, however, that it is all wrong for these special tests to precede a general examination. We understand that certain physicians dealing particularly, we hope, with well-to-do people are accustomed to order practically everything that the hospital laboratory can furnish in the way of laboratory diagnosis as soon as the patient enters the hospital. Not unlikely valuable tips are received by this means occasionally, but it is also dead certain that a great many incidental findings tempt the diagnostician into blind roads entirely unrelated to the particular set of symptoms which sent that patient to the hospital. The patient is charged a considerable sum for these examinations and the physician is sometimes misled by them. The patient should have been examined first in a general way with particular regard to the complaint, and then he should have been asked to submit to such special tests as seem to be indicated or to be possibly significant.

When the laboratory becomes the servant of clinical diagnosis it will fulfill its best function. It should, however, follow and not lead.

We wish to insist upon the principle that special tests should follow general examinations.

CRIME

A few Christmases ago the late Pope Benedict, speaking before the College of Cardinals, assigned as the foremost plague affecting humanity an unprecedented challenge to authority, and as other symptoms of the same malady an abnormal aversion to work and an excessive thirst for pleasure as the great aim in life. Almost every individual has a theory about the production and treatment of crime. Every profession has made its offering. In about 1890 Cesare Lombroso, an Italian physician, expounded the first application of positive induction methods of science to the study of human and social activities. He felt that anthropology would explain it all; that the reversion theory would explain sufficiently. He lived and studied long enough to change his own hypothesis. There are those who note an apparent parallelism between the convicted and poverty. Hence the causative factors in these "cancers of society" are as problematic as the causative factors in "tissue cancer," for which most laymen have an explanation. We do know that certain combinations of factors show some predestiny.

Today we know from figures that 97% of men convicted to die are executed; that only one out of every 80 murderers receives the death penalty; that most of the others convicted do return to society sooner or later.

The recent break of convicts from an Indiana prison has caused no small amount of interest and comment because of existing circumstances. We are not taking sides in this situation, but do wish to call attention to some matters existing in our state for several years. What is true here may well be true in our sister states. Overcrowding by as much as 60% has existed. Parole has been necessary to make room for others coming in. Yet a parole office has a case load so great that the

"ex-convict" cannot be followed more than one year. Seventy-five per cent of all paroles appear to do well the first year; 25% of them have to be returned. In the prisons there are four main methods of discipline: (1) merits and demerits for good time; (2) solitary confinement; (3) electrotherapeutics in the form of a chair; and (4) work. Supposedly the last method is the most praiseworthy and far-reaching. Yet in our prisons there are five men for every job. The resulting idleness leads to viciousness. After 1934 this idleness will become greater by virtue of the Hawes-Cooper Act, which prohibits the interstate commerce of prison-made goods. The Department of Correction in New York State made an approximate analysis of the force of prison-made goods versus competing free-made goods for the year of 1929. Prison labor manufactured 13/1000 of 1% of the goods studied; of the total number of laborers manufacturing these products 15/100 of 1% were in penal institutions. Now comes the NRA insisting that every man needs a job, not only for his physical but also for his mental welfare.

We also can find on our own statute books a law prohibiting one of our penal institutions from marketing a product which had never been manufactured to any extent in Indiana prior to the time that the institution went into that business.

It is roughly estimated that 25% of the prisoners will not work and are hopeless; 25% of them represent some definite form of psychopathy and yield varying results by occupational therapy as would be expected; the remainder does leave a field for speculation, and as Dr. Amos Butler of Indiana once said, "Whatever our prisons do, they should not make men worse."

EDITORIAL NOTES

PAY your 1934 dues now and get it off your mind.

To each reader of THE JOURNAL we extend best wishes for a Merry Christmas.

CHIROPRACTORS, at their recent convention in Indianapolis, expressed the intention of attempting to secure a special board at the next session of the legislature. We think the present board handles the situation effectively.

THE Bureau of Accounting of the Indiana Division of Public Health reports a saving of $11,194.38 for September, 1933, over September, 1932. The total saving for the first quarter of the present fiscal year is $31,923.26. Figures don't lie.

IT SEEMS that we spent the sum of $144.78 in presenting to the lay public certain exhibits at the Indiana State Fair. It is estimated that 25,000 Hoosiers saw the exhibit, 2,500 of whom had their blood pressures recorded. Many an advertising agency would deem this money well spent, and so say we.

THE monthly bulletin of the Indiana Division of Public Health gives favorable mention to the plan of the Wabash County Medical Society for its work as designed to take the place of activities of the former division of infant and maternal welfare. The plan includes pediatric lectures, which will be given under the auspices of the Wabash County Medical Society. What is your county medical society doing?

IT is with regret that we note the passing of Dr. William Ray Bathurst, for some fourteen years the editor of the *Journal of the Arkansas Medical Society*. Dr. Bathurst issued a most creditable journal and we thoroughly enjoyed his comments on various phases of professional matters. The October number was issued as a memorial to him and was replete with comments from various medical men of the southwest.

WHAT about paying your dues this month instead of waiting for 1934 to arrive? From an experience of several years we can assure you that your secretary could have a no more appreciated Christmas present than for every member of his society to pay his dues before January first. Could that happen in Lake County we would put on a New Year's party that would more than astound the Ruth Street neighbors!

QUOTING from a letter received by a northern Indiana physician from a former patient, who had moved into a central Indiana city: "This town where we are living has a slight epidemic and the doctor here doesn't even know of the '..... test,' *and he isn't very old either.*" It's an even bet that said doctor either does not belong to his

county medical society or, if he is a member, he does not read THE JOURNAL.

THE annual Secretaries' Conference has been scheduled for January 21, 1934, at the Indianapolis Athletic Club. Tentative arrangements are for a six-hour program, with a dinner between sessions. All members of the Indiana State Medical Association are invited to the conference, also to the dinner; the latter is complimentary to all county society presidents and secretaries; the hoi polloi are invited to dine, but at personal expense. Fuller details will be noted in the January number of THE JOURNAL.

AT the French Lick session the House of Delegates voted to have a codification of our Constitution and By-Laws. This is a most necessary thing; we have been operating under the present code since 1926 and during that time almost innumerable changes have been made, making for no little trouble in determining just what the "law" may be in many instances. It is to be hoped that the committee in charge will get into action at an early date, as the task is of no small moment and will necessarily require quite a bit of time.

DR. WILLIAM N. WISHARD, that "grand old man" of Indiana medicine, recently made it plain that there is no point to prefacing a radio broadcast with the statement that the speaker is "Dr. John Smith, the well known specialist," or "John Smith, one of our prominent physicians." He avers, much to our delectation, that it is far better to say, "This speaker is sponsored by the blank county medical society." He declares that such a preface will carry far more weight and authority and, as usual, Dr. Wishard is correct in his pronouncement.

A LITTLE note in the address of President-elect Padgett before the first meeting of the House of Delegates at the French Lick session is worthy of more than passing notice. In speaking of our relation to organizations dealing in health matters he said: "It behooves us to cultivate a friendship and to work in closer union with these agencies, i. e., boards of public health, the State Tuberculosis Association, the State Nurse's Association, the State Dental Society, and others." During the past few years there has been an increasing tendency on the part of our officers to cooperate with the various organizations so closely allied to our profession and it is refreshing to note that Dr. Padgett proposes to keep alive these contacts.

THE Editorial Board has an established policy that editorials appearing in THE JOURNAL shall not be signed or initialed. We are, of course, in entire accord with that policy, but because of a combination of circumstances we feel that it is proper that the editor make the statement that he is solely responsible for the editorial concerning Kingsbury and the Indiana State Board of Health, which appears in this issue. The editor believes that the editorial represents the opinion of the medical profession of Indiana in resenting some uncalled-for statements appearing in the Kingsbury article as reported by the lay press. This information is given for obvious reasons; we do not care to have anyone get the impression that the editorial in question originated in or came from the Indiana Division of Public Health.

A VERY readable group of reports, four in number, appeared in the November eleventh issue of *The Journal of the A. M. A.*, having to do with the use of cosmetics on and about the eyelashes. Three cases of a most violent conjunctivitis with consequent lid edema and one case of corneal ulcer are reported. Fishbein comments on the situation, citing several other reported cases. "Lash Lure" was the offending agent in three of the reported cases. This reminds us of several cases of lid inflammations, some with ocular conjunctivitis, which we have seen, several of which we thought were traceable to face powders. Occasionally we have been advised by our feminine patients that they are unable to use face powders made with certain bases. It is odd that the federal government has not stepped into this field along with the food and drug activities.

AN editorial in this issue, written by a laboratory man, directs attention to what we believe to be an ever-increasing tendency to have too many laboratory examinations and to depend too much on the findings thereof. We have long held the opinion that some of our younger men, fresh from the laboratories of the modern medical school, are too prone to order wholesale examinations from the hospital lab rather than depend to a very great extent on the findings incidental to a complete physical examination of the patient. The editorial calls attention to the many ways in which a laboratory report may lead one to false conclusions and we have known instances in which an incorrect

diagnosis was made because the physician accepted the laboratory report rather than his own findings. Then, too, the matter of expense is no small item, much of which is obviated by the exercise of a little medical common sense.

WE would again remind delinquent members that the directory of the American Medical Association, the most informative work of its kind, goes to press shortly; the classification of medical men is such that it is quite worth while to be among "the elect," which is accomplished by the very simple expedient of being in good standing in your local county society. The recent report from headquarters shows our membership, as of November first, to be 2,643, a loss of 67 over 1932 at the same date. When we look over the membership decrease in some state societies we have every reason to be proud of the Indiana record. However, there should be no decrease in our state; if but one member in each county were added to the roll we would have a gain over 1932. Our observation is that some delay payment of dues through sheer negligence, some because they simply cannot "spare" the necessary amount, while others are delinquent through pure cussedness, whatever that may be.

THE "swan song" of the retiring president, Dr. Weinstein, in this issue should command the attention of every member. It comes from a man who has devoted an enormous number of hours in an attempt to solve some of the many economic problems that have been attracting our attention lately. That he has done his work well is evidenced by the unstinted praise that has been heaped upon him all over Indiana. In sending in his message "Joe" writes: "I hope you do not feel I have let off too much steam; nevertheless, that is the way I feel about it." No, he hasn't let off too much steam; fact is, we got all steamed up about that letter, too! In bidding Dr. Weinstein adieu as the head of the Indiana State Medical Association for 1933 we are sure we express the opinion of our entire membership in extending to that gentleman our most hearty thanks for the accomplishments that have been his. We hope to have the benefit of his counsel and his observations for many years to come.

DOWN in Mississippi they have a novel system of getting out their journal, which is combined with the *New Orleans Medical and Surgical Journal*. They have an editor for each county society, who is presumed to make monthly reports of the goings-on in his bailiwick. Many of these chaps write in a quaint, conversational style which reminds us very much of the country correspondents in the county seat newspaper down in the region of Wild Cat, Carroll County, where we grew up. We like that sort of material, even in a medical journal—a homely recording of the doings of medical men in rural communities. What impresses us in reading these letters is the prevalence of malaria down that way; one tri-county society, with Vicksburg as its center, recently passed a resolution urging that steps be taken by local authorities to bring about a mosquito-free community. Another county editor most entertainingly details a personal experience while on a shrimping expedition; it seems that he fell off the wharf and, in the process of getting out of the water, lost his glasses, and this necessitated several nose dives, much to the delectation of his companions. One chap was complaining of the heat at a recent county society meeting; he wrote: "Even though it was awful hot we got cooled off with some of the best bottled coffee that I ever tasted. No one took time out to ask the brand—it was all good." We'll wager that it was at least 3.2!

IN his presidential address at French Lick Dr. Weinstein again brought up the problem of state hospitals and private patients therein when he referred to a part of former president Crockett's address: "Conduct of the medical school and hospitals should be such as to keep the state free from competition with the private practitioner." This is one of the problems that has been before us for many years and is as yet unsolved. There is still much justifiable criticism in the matter. Indiana physicians, as a rule, hold that the medical school and the state hospitals (those of the general variety, we mean) are for teaching purposes; this being true, we feel that they should be exclusively such. We have spent a lot of time and effort in attempts to break down the former barrier between the medical profession of Indiana and certain of the state institutions, notably the medical school and the State Board of Health; just now, when it seems that we are in a fair way to take the final hurdle, it does appear that cause for the present complaint might well be removed.

WHAT price publicity! And how do they get away with it? We are in receipt of clippings from *nine* Indiana newspapers, each containing, almost verbatim, an editorial regarding an address made by the head of a large Cleveland clinic at the recent meeting of the American College of Surgeons in Chicago. In the same envelope are two clippings, also from Hoosier papers, concerning an address made by one of the heads of a larger clinic at Rochester, Minnesota. It stands to reason that these various editors wrote not one whit of the material presented, for nine editorial writers would not and could not approach the same subject from the same viewpoint; at any rate they would not use the same language in expressing their thoughts. Some time ago one of our medical societies took to task one of its members because of undue pub-

licity that he was getting in the local press. His answer was that the larger clinics of the country were engaged in the publicity business, so why pick on a little fellow? Newshounds attend the larger meetings if allowed, and it is but natural that they should seize upon choice morsels of scientific interest to the lay public, but just how articles such as the one in question happen to hit all sections of the Hoosier state at one and the same time is beyond us; of course, we cannot accuse the clinic heads of complicity in the matter!

A THING that formerly had been regarded as just another of the petty shortcomings of certain members of the profession seems now to have developed into a racket of no mean proportions; we refer to the sale of "physicians' samples" by some of the profession. For a good many years we have heard of instances of physicians sending for samples of anything that seemed usable and, in turn, handing the samples out to patients, not forgetting to collect a fee for same. Recently a detail man explained just how far this thing has gone. He said that in the city of Chicago there exists what may be termed a "clearing house" for these samples; agents for the concern make regular trips to physicians' offices, buying samples of all sorts for a small percent of their real value. These are sorted, catalogued, and a printed list submitted to certain retail druggists who will buy such truck at a fraction of the market price. Our informant declares that a druggist showed him such a list and made no bones about admitting that he was a regular purchaser of such bootleg materials! Our opinion of the whole matter is certainly an uncomplimentary one and we would have no dealings with a retail druggist who abetted such practices. A physician who will lend himself to such a practice should be summarily dealt with, at least to the extent that participation in such activities be thoroughly exposed.

IT seems that our article on "Group Hospitalization" some few months ago, ably presented by Secretary Hendricks, got right under the hide of a chap in Chicago, who writes a protest covering several pages. In conclusion he says: "It is to be hoped that the Indiana State Medical Association will give this subject considerably more thought than has been evidenced by the proceedings thus far, and that more effective efforts will be made to secure authentic information about it from sources other than those whose sole interest is the potentiality for profits." Well, well, well! Our good brother feels that we went off half-cocked, does he? For his edification we may say that the Indiana State Medical Association was one of the first to attack this problem in any manner; was the first to hold special committee meetings for its discussion and analysis; *was the first to publish a comprehensive picture of the whole set-up.* Yet we hear, from a neighboring state, a mighty wail to the effect that we gave too little attention to the matter before saying what we thought about it! We handled this situation just as we did the indigent medical relief problem—intelligently; we made a decision only after we had studied the problem in all its details; we made a decision, published it, and it was well received over the country judging from the response it has had. We have nothing to retract and we see no occasion for changing our opinion in the matter, even though it may meet with disfavor in the eyes of this Chicagoan.

A RESOLUTION passed by the House of Delegates at the French Lick session provides "That any member who takes part in an organization of the health insurance type which is not approved by the Executive Committee of the Indiana State Medical Association shall be automatically suspended from membership in his county society and the Indiana State Medical Association, and cannot be reinstated until he severs his connection with the organization which is not approved." Our attorney, Mr. Stump, holds that this resolution conflicts with our Constitution, which expressly states that "each county society is the judge of its membership." The Executive Committee now recommends that the various county societies adopt such a resolution, with which idea we are in entire accord. There is no place in an Indiana county society for a member who enters into such an unholy alliance as is usually proposed by commercial health insurance organizations. We recommend immediate action on the part of every county society in Indiana. The Indianapolis (Marion County) Medical Society already has adopted a resolution which, for the information of other county societies, is printed in full:

Whereas, The members of the Health Insurance Committee of the Indiana State Medical Association have investigated a number of so-called health insurance plans covering group practice with limited selection of physicians, and have found no responsible organization with a satisfactory plan to give adequate service to patients or pay adequate fees to the physicians; and

Whereas, Many members of the Indiana State Medical Association may be persuaded to enter those organizations without knowing their financial responsibility, or how these organizations may affect ethical relations in the profession; therefore

Be It Resolved, That no member of the Indianapolis Medical Society may be allied with an organization whose purpose is to supply medical service to a group of individuals, unless the said organization is approved by the Executive Committee of the Indiana State Medical Society; and be it further

Resolved, That any member who takes part in an organization of the health insurance type, which is not approved by the Executive Committee of the Indiana State Medical Association, shall be automatically suspended from membership in the Indianapolis Medical Society and the Indiana State Medical Association, and cannot be reinstated until he severs his connection with the organization which is not approved.

THE PRESIDENT'S PAGE

Are we on the spot?

A letter received recently by the headquarters office from one William H. Walsh, M. D., P. H., of Chicago, apparently expressed the hope that such is the case.

His inditement and severe criticism of the position taken by the Indiana State Medical Association in regard to group hospitalization would be very mortifying were it not so amusing.

Without reading very far in his letter it soon becomes clear to the reader that the writer is not earning his livelihood by private practice, and that in some way his pride has been wounded. Proof of the latter appears in the letter where he says, "*The ideal plan formulated by my office* * * * a copy of which was before your committee."

He accuses us of not investigating, of not having facts, of taking only the testimony of private insurance companies looking for "inordinate profits." Not directly, but by implication, he accuses the Committee on Health Insurance, the Committee on Civic and Industrial Relations, the Executive Committee, and the officers of ignorance of the question involved.

Your committees and officers had studied and were familiar with practically every plan in operation or attempted operation. Letters, books, pamphlets, and articles collected by the headquarters office and officers, read and discussed, would make quite a presentable library.

But your association was the first and only one to go directly to a source of information more capable than any other agencies to give an opinion based upon actuarial facts of years of investigation and experience with illness. Then since the published opinions are at variance with the doctor's own opinions and are a hard knock to his own plans, he takes umbrage and waxes wrathy.

No voluntary association of this type can long exist. They sooner or later must fail or become compulsory, and compulsion is admittedly a goal towards which practically all types of health insurance workers aim. When compulsion enters, politics is its partner; one does not travel without the other; they must go hand in hand. This is as true of group hospital insurance as of any other type of health insurance.

The medical profession sympathizes with the hospital in its serious economic plight. In many cases this has arisen from over-expansion or the acquisition of luxury. With the physician suffering from reverses the same as all classes of business, institutions, and people, one cannot expect the physician to assist the hospital to a position of temporary affluence when he feels this position to be only temporary and at the same time be detrimental to his own economic condition. Should some social worker read this last sentence I can hear him say, "That's a very selfish thought, thinking of your own good." God bless you, may we never give ourselves a thought? May we never think of our families?

Does a social worker never think of self? How about pay day? Are salaries refused? Advancements turned down? I think not. Unfortunately, many social workers are not even thinking. They are doing their master's bidding, whose eyes are turned to some distant horizon envisioning experiments and idealizing them for home consumption.

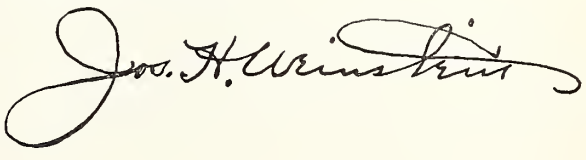
I am sick and tired of European monomania. The continuous harping back to how things are done in Germany, France, England, or some other foreign country is nauseating. Have they made such a marvelous success of life over there that you will be willing to change countries? Are we nothing but parrots or magpies? Have we no initiative that we must follow others? Have we ceased to be captains of our souls, or shall we humbly bow our heads and in submission say:

Whither thous leadest, O Europa, we follow;
We ask not to reason why,
We ask but to do and die,
As we did in 1918!

Our Association is more organization conscious than ever, and under the able leadership of your new president, Dr. Padgett, its efficiency and effectiveness will continue to increase.

My term of office and the many pleasant associations resulting from it will always remain in my memory as the happiest period of my life, and again brings proof that there exists no finer group of individuals than physicians.

In this, my farewell presidential message, I wish again to express my deep appreciation for the cooperation given your officers throughout the year in helping us solve the many difficult problems that have arisen. I wish it were possible to thank you each individually.



DIPHTHERIA IMMUNIZATION CAMPAIGN

The first week in December has been suggested by the Executive Committee of the Indiana State Medical Association as the time for all county medical societies to hold meetings to discuss and, if thought desirable by each local medical society, to make plans for a local immunization campaign against diphtheria and smallpox. Detailed suggestions for such a campaign have been supplied by the Executive Committee and the State Division of Public Health to the officers of each county medical society and local health officers.

The Advisory Council of Public Health, composed of the following agencies and organizations, has given this movement its full and hearty cooperation: Indiana Congress of Parents and Teachers, the Forty and Eight, the Indiana Chapter of the American Red Cross, Indiana State Nurses' Association, the Indiana Tuberculosis Association, Indiana State Department of Public Health, Indiana University School of Medicine, Indiana State Dental Association, and the Indiana State Medical Association. At the last meeting of the Advisory Council, the following resolution and recommendation were unanimously adopted:

"It is the unanimous opinion of this committee that the most urgent need in public health in Indiana today is immunization of the child against diphtheria and smallpox.

"It is recommended that each county medical society work in harmony with the Indiana Congress of Parents and Teachers, the American Legion, and other lay organizations to the end that lay organizations stimulate public interest in the matter and bring the children to the family doctor for immunizing. Family doctors shall charge their usual rates for immunizing children of parents able to pay, and, in case there are at hand no means for paying the doctors for immunizing indigent children, the doctors shall then immunize such children free of charge. Each county medical society is requested to specify certain days and hours at which time indigent children will be immunized by the family doctor."

It is up to each local county unit to organize the lay organizations to assist. The Forty and Eight of the American Legion has offered toxoid to immunize all *indigent* children up to and inclusive of ten years; also the state has made a grant to furnish toxoid and vaccine under the same conditions. Especially should the assistance of local groups of the Indiana Congress of Parents and Teachers be obtained to aid teachers and school superintendents to secure the cooperation of parents of the indigent children to grasp this opportunity, and at the same time urge all parents who are able to pay to take their children to their family physician.

It is not the intention of this campaign to immunize free any child whose parents are able to pay the physician. It is the intention to, so far as possible, immunize every child under ten years of age:

First, those unable to pay, free, either by the family physician or by groups at schools or especially arranged clinics.

Second, those able to pay, either at home or office by the family physician.

The doctor shall be the final judge as to the ability of any patient to pay.

Activities should begin at once, as all plans are laid with the idea in view of getting at least sixty per cent of children in this age group immunized almost simultaneously all over the state; therefore, December fifteenth has been set as the dead-line date to start the actual work of immunization. This is the last date that the State Department of Public Health can be notified to supply toxoid that is to be used in indigent cases.

The work has already started in several counties. If your county is not numbered among these, your society should get interested and start immediately. The responsibility is on the medical profession, and this work will demonstrate either the profession's ability or inability to handle public health questions.

A letter in regard to this work has been sent to the health officers of each county by Dr. Verne K. Harvey, state health director, asking health officers to cooperate with the local county medical society and the physicians in arranging for this work.

HOW ONE COUNTY SOCIETY CONDUCTED ITS CAMPAIGN

THE CARROLL COUNTY IMMUNIZATION PROGRAM*

The Carroll County Medical Society put on an immunization program during the falls of 1932 and 1933 which was very successful. The first step was to ask the members of the medical society whether they would approve the general idea of such a program to be carried on in the schools, the details to be worked out and presented to the medical society for approval later. This was approved and the president of the society appointed a committee to work out definite plans.

After several meetings the committee presented the following plans which were approved by the medical society:

A county-wide program of immunizing and vaccinating would be offered the public, all work to be done at the schools. The toxin-antitoxin would be given in the first campaign and the smallpox vaccinations in a later campaign. The amount charged for the toxin-antitoxin could be paid at one time or in payments as the shots were taken. The money for smallpox and the Schick test would be collected when this campaign was put on. The offer would be open to people of all ages if present when the doctors worked in the schools. Actual immunizing would be preceded by an educational campaign in all schools of the county. (This educational campaign was put on

* This article prepared by Esther Gregg, R. N., public health nurse, at the request of Carroll County Medical Society officers. Dr. Eva Kennedy, president, and Dr. E. H. Brubaker, chairman of the immunization committee.

by the State Division of Public Health at the request of the medical society.) No school child would be immunized without written consent of his parent. All supplies would be purchased by the immunization committee, all expenses paid out of the money collected, and any funds then left would be divided equally among the doctors who helped with the campaign. Each doctor was to be present at the school when he was scheduled or be personally responsible for having a substitute there on time in his place. The work of scheduling the talks in the schools by the representative of the State Division of Public Health, of getting publicity, of scheduling two doctors to each school for the immunizing, of sending each doctor a post card with his schedule on it, of sending each school notice of the doctor's visit to that school and of furnishing the consent blanks to the teachers for each child was delegated to the county nurse by the medical committee.

Throughout the plans for the work, the county superintendent of schools, the trustees and the teachers were kept informed, and splendid cooperation and much publicity was thereby obtained. Consent blanks were mimeographed from the office of the county superintendent of schools. Responsibility for sending to the doctors at the school only those children who had consent of parents was placed squarely on the teachers.

The medical committee contacted the trustees and asked each trustee to give out of his special school fund a sum (on a sliding scale from $50.00 down to $20.00 according to school enrollment) of money to help buy the biologicals for the campaign and for that help the doctors agreed to immunize all who could not pay. Each trustee paid the requested sum.

No publicity was given to the plan to care for those who could not pay. Teachers and trustees reached these people by personal contact and quietly obtained consent. Four visits were made to each school to give toxin-antitoxin, feeling that after the first visit many would wish they had taken advantage of the opportunity. Some 450 additional shots were given on the second visit. Children who started and lost out on account of illness were cared for in the doctors' offices with campaign biologicals.

Two schools were scheduled each morning and one for the afternoon. We reduced the number of set-ups to fifteen by having trustees bring small schools to larger central schools and were thus able to cover the county in one week, repeating the same schedule each succeeding week for toxin-antitoxin. "Canned" heat was used to sterilize needles. All supplies were carried from school to school by the nurse. Washing arms, keeping records and collecting money was done by lay people or pupils. Every practicing physician in the county took part in the campaign and its success was due to splendid team work.

MATERNAL WELFARE

Below is a copy of a letter sent to each county medical secretary. It is hoped that each local unit will assume responsibility for better maternal care in its own community.

This letter was sent to the secretary with the feeling that he would be best able to promote this work locally, or would ask his local society to choose from the membership a member or a committee especially interested in obstetrics and assign to them the responsibility for this program.

We are aware that a few societies already have existing committees on maternal welfare and, of course, these committees will be in a position to assume the work suggested herein. We are gratified to know that some counties have this important work well in hand.

Certain groups of counties are now uniting in their plans to give postgraduate programs on obstetrics and programs for the laity on general maternal welfare, and it is to be hoped that all sections of the state will carry out definite plans toward better obstetric care and lower maternal and neo-natal death rates.

The important point to be remembered by all local units is that this work is no longer being carried on in your community by the State Board of Health, and that unless it is taken up by the local society and carried on it will not be done, and maternal mortality rates will soon reflect the lack of conscientious effort.

To Secretaries of All County Medical Societies:

With the new organization of the Indiana State Board of Health I have been asked, by virtue of my position as Professor of Obstetrics at the University, to work with the Board of Health in an advisory and educational way in promoting better maternal health for the state.

It has been determined, as a general policy of the State Board of Health, that each locality should as nearly as possible be responsible for the local problems in health and preventive medicine.

Therefore, I am herein submitting a beginning or tentative plan which I hope may tend to promote better obstetric care:

1. This letter goes to each county secretary.
2. It is hoped that each secretary or someone delegated by him will take special interest in maternal welfare. It cannot fail to work to each physician's advantage to have the laity in his own community well informed as to better obstetrics and better obstetric care. Just as soon as the laity understands more as to the advantages of proper maternal care the physician's services will be better appreciated and the plane of obstetrics will be elevated in that community.

3. As a suggestion of some ways of educating the laity I am inclosing a brief outline, enumerating 11 points.
4. In so far as possible the State Board of Health will furnish to physicians, upon request, certain pamphlets, graphs, charts, and moving pictures for use in addressing or circularizing lay organizations. We believe these should be used freely and gotten into the hands of lay women, and especially pregnant women.
5. We believe that parent-teacher associations are often the best organized and are very willing to help in matters of this kind. In your community there may be other and better organizations.
6. As a suggestion it may be possible to arrange in your community some afternoon for post-graduate talks or clinics on obstetrical subjects for physicians only, then possibly an evening hour for physicians and laymen where the general subjects of preventive medicine as applied to obstetrics could be presented by speakers able to address lay audiences.
7. Continuous effort will be necessary if real good is to be accomplished.
8. It is recommended by the State Board of Health that each county medical secretary familiarize himself with speakers willing to be called upon, and when possible we should appreciate being given these names.
9. The Department of Obstetrics at Indiana University stands ready to suggest, advise, and assist so far as is possible in promoting better obstetrics in our state.

Yours truly,

A. M. MENDENHALL.

EDUCATE MEN AND WOMEN CONCERNING THE IMPORTANCE OF OBSTETRICS

1. Seventeen to twenty thousand women die annually in the United States of the child-bearing process.
2. Educate the laity that one-third of these are due to sepsis; one-third to toxemia; and that nearly all sepsis deaths and nearly all toxemia deaths should be prevented.
3. This should not be used in the nature of a scare, but rather as statistical facts showing what good obstetrics can do.
4. Educate men to know the importance of the child-bearing process.
5. Educate women to go to the doctor early in pregnancy. Educate them to select a doctor known to give good care in obstetric cases and to go regularly to see him.
6. Educate women as to what good obstetric care means.
7. Educate them as to diet, exercise, sleep, rest, and general pre-natal care.
8. Educate them as to delivery care and what constitutes good care.
9. Educate them as to good after care.
10. Educate them that all pregnant women need good care throughout pregnancy, labor, and puerperium.
11. Educate them that the best American stock is decreasing and that motherhood should be one of woman's greatest hopes, and if the mother is properly cared for during child-bearing there should be little to fear.

DIPHTHERIA REPORT FOR OCTOBER, 1933

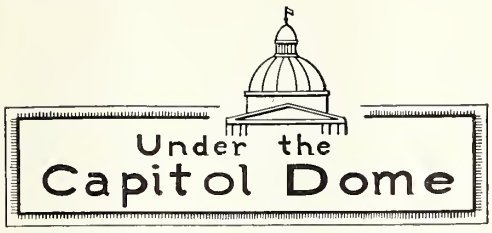
That there is need for an immunization campaign against diphtheria is clearly shown by the number of deaths for the month of October, namely, twenty-four for the entire state. This is exactly in accord with figures for previous years, inasmuch as there is always a sharp jump in October, which carries through the next two or three months.

Bartholomew County heads the list in October with four deaths. Considering the size of the county, that is a very serious epidemic. Vanderburgh County has three deaths, and Jackson, Marion and Tippecanoe counties each has two. Several counties entered the black list for the first time.

If anyone is unconvinced concerning the need of a diphtheria immunization campaign, let him consider the fact that twenty-four people died during the month of October. This is practically one death for each week day. As the figure now stands we have ninety-five deaths for the first ten months of the year. Unless there is a definite checking of the disease, our figures this year will be higher than for the years 1930 and 1931.

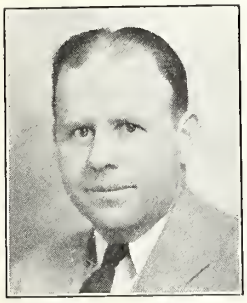
Following will be found a list giving the distribution of deaths for October and for the year 1933 so far.

County	Total for 1933	October 1933	County	Total for 1933	October 1933
Adams	1	1	Morgan	1	0
Allen	9	0	Noble	1	0
Bartholomew	5	4	Orange	1	0
Blackford	1	0	Owen	1	1
Clark	1	1	Parke	1	0
Daviess	2	0	Pike	1	0
Delaware	1	0	Randolph	1	0
Dubois	1	0	Ripley	2	1
Fayette	2	0	Shelby	3	1
Floyd	1	1	Starke	1	0
Fountain	1	0	St. Joseph	1	0
Fulton	1	0	Sullivan	4	1
Gibson	1	0	Switzerland	1	0
Greene	3	1	Tippecanoe	5	2
Hancock	2	0	Union	1	0
Harrison	1	0	Vanderburgh	6	3
Howard	1	0	Vigo	2	1
Jackson	4	2	Warren	1	0
Knox	1	0	Warrick	1	0
Lake	2	0	Wayne	3	1
Lawrence	2	0	Wells	1	0
Madison	1	0		—	—
Marion	10	2			
Monroe	2	1		95	24



THE BUREAU OF HEALTH EDUCATION

In the reorganization of the old State Board of Health the Bureau of Health Education took over the work of the Child Hygiene Division and that of the Department of Visual Education. Under the new Indiana plan for health education this bureau acts as a contact medium and helps carry on the work for persons or groups wishing health programs and the new set-up arranged by the Indiana University School of Medicine in cooperation with the Indiana State Medical Association to direct health education in the state. This set-up for health education is described in detail under "The New Plan for Child Health and Maternal Welfare."



Bynum Legg, Director
Bureau of
Health Education

When the bureau receives requests they are referred back to the local county medical society, which may either take entire charge of the program or may approve arrangements made through the bureau. If the local society desires, a speaker from outside the community may be secured, but as a rule local physicians are ready and willing to make their own talks.

This plan, recognizing the idea that correct public health practice is not antagonistic to the private practice of medicine, turns the health education of the people back to their own physicians, who know their needs and who know the background and the capabilities of the community. In this way these programs become really community programs carried on under the direction and supervision of local county medical societies. This bureau is at all times ready to serve the lay public and the medical profession.

Health motion picture films are available for showing in connection with talks by physicians or in programs which they approve.

Pamphlets are available upon request on infant and maternal hygiene and the preschool child, also literature on the subject of preventable and communicable diseases. Attractive poster exhibits on a number of health topics also are available for display in connection with health programs.

Paul P. Fry, state excise director, reports that a total of 208,474 pints of medicinal whisky has been sold in Indiana since the sales were legalized on April 7. The report covers the period April 7 to November 1. The excise tax, amounting to twenty-five cents per pint, brought in a total revenue of $52,118.50 to the state. According to Mr. Fry, the department is experiencing little difficulty in administering the medicinal whisky laws.

Progress in the state's free medical service for indigent families was reported by William H. Book, director of the unemployment relief commission. A few agreements already have been signed, and negotiations with local physicians are in progress in a large number of counties.

A contract already has been entered into in Clay County, while negotiations are in progress in Vigo, Clark, Cass, Sullivan, Pike, and St. Joseph counties. An agreement also has been reached in Calumet township, Lake County.

Following is a list of physicians who have located in Indiana, through reciprocity, during the month of September:

Charles B. Kenney.....East Chicago, Ind.
Louis N. Podesta.....Lawrenceburg, Ind.
Henry J. Zimmer.....Mishawaka, Ind.
Earl W. Bailey.....Bunker Hill, Ind.
Charles B. Emery.....Bedford, Ind.
Rayburn C. Austin.....Franklin, Ind.
Harley F. Flannigan.....Upland, Ind.
George S. Row.....Upland, Ind.
Charles W. Olcott.....Aurora, Ind.
Joseph J. Cacia.....Newburgh, Ind.
Frederick A. Loop, Jr.....Lafayette, Ind.

What changes will be made in regulations of sale of medicinal whisky when the Eighteenth Amendment is repealed is a matter of considerable speculation. The excise director himself has offered no comment upon the situation. However, it is known that Philip Lutz, Jr., attorney general, has held, in an unofficial opinion to the governor that the excise director has full authority to make regulations for control of whisky when the amendment is limited. At any rate, the need for prescriptions for purchase of whisky will be eliminated by any rules broadening the sales of the beverage. Some observers believe that the prescription system will be entirely eliminated, so far as the actual purchase of whisky is concerned, and physicians who prescribe whisky for patients will simply advise them to purchase the beverage and will not need to write a formal prescription.

Physicians and surgeons paid more income tax during the last taxpaying period than any other professional group, according to statistics in the gross income tax department.

Although the doctors paid the greatest amount of tax, their average payments were not so great as the average in some other professions.

For the July paying period, the last for which statistics are available, professional men paid in $48,979.93, which was a total of 2.8 per cent of the entire income tax collections. Of this amount, physicians and surgeons paid $15,003.70, or .86 per cent of the state total. The average payment for physicians and surgeons was $7.39, an average less than that of several other professional groups, but larger than the average for chiropractors, osteopaths and podiatrists which was $3.12, and for dentists, which was $4.27. Engineers and architects showed the largest average individual payment. Their average was $20.18. Funeral directors had the next highest average, $15.42 per taxpayer, and attorneys, with $10.26 average payment, third highest. Optometrists, opticians and oculists showed an average of $9.37 per taxpayer.

The records showed that more doctors made their income tax payments than representatives of any other professional group. A total of 2,030 physicians and surgeons paid the tax, while only 1,221 attorneys and 804 dentists paid.

The total taxable income of physicians and surgeons reporting for the July taxpaying period was $1,906,051.86.

The statistical department of the gross income tax department figured out that one physician or surgeon paid tax to every 1,595 persons living in the state. They also determined that the physicians and surgeons paid 4.6 mills tax for every inhabitant of the state.

Manufacturers of medical, chemical and beauty products—which are lumped together for the tax department's tabulations—paid $4,002.29 tax, on a gross income of $1,500,313.91. There were 116 manufacturers reporting, and their average tax was $34.67.

Clarence A. Jackson, director of the income tax department, called attention to the fact that every Indiana citizen must pay his income tax in January, this payment being for receipts from May 1, to December 31. Deductions will be made, of course, for payments previously made. Every individual who has taken in more than $666.67 during the eight-months period, is subject to the tax.

Costs of a state-wide public health program aimed to cut the diphtheria mortality rate in Indiana, and to provide free immunization of all children whose parents cannot afford to pay for treatment, were underwritten by Governor Paul V. McNutt.

The Governor authorized a transfer of funds in the state division of public health sufficient to buy immunization materials for the treatment of 75,000 children between the ages of six months and ten years. The treatments will include immunization against diphtheria and smallpox for all children of indigent families.

The materials will be dispensed through Dr. Verne K. Harvey, director of the state division of public health, in accordance with a plan developed by the Indiana Advisory Public Health Council. This council includes the Indiana State Medical Association, the Indiana State Dental Association, the immunization committee of the Indiana University School of Medicine, the Indiana Parent-Teacher Association, the American Red Cross of Indiana, the Indiana Nurses' Association, the American Legion, Forty and Eight, the Indiana Tuberculosis Association, and other health and child welfare volunteer organizations.

Governor McNutt authorized the expenditures by the state division of public health after reviewing a report of the division which showed that savings in operating costs of this branch of state government have amounted to $44,000 through the months of July, August, September, and October.

The cost of immunizing materials for the needy children of the state will not exceed $15,000, the state health authorities assert.

The plan, in which the Indiana State Medical Association will take a prominent part, calls for organization by district and county medical societies. Members of the medical profession, through the association, have pledged their full cooperation, and under the program local family physicians will render services free to those in their respective neighborhoods who cannot afford treatments.

"Even though marked improvement has been made in the control of diphtheria in the last few years," Dr. Harvey said, "still our statistical reports show that an average of one child for each school day has died of the dread disease in the months of October, November and December. It is hoped that all parents will take advantage of this opportunity. Those unable to pay nevertheless will go to their private physician and sign cards requesting the free immunization. No children will be given treatments unless parents specifically request it. If half of the children of Indiana are immunized against these two diseases, the death rate will be reduced to a small fraction of the present rate."

SECRETARIES' COLUMN

The next annual meeting of the county secretaries will be held on January 21, 1934, at the Indianapolis Athletic Club, beginning at two o'clock in the afternoon.

It is the desire of the committee that the secretaries and presidents of all the county societies, all the officers of the state society, and all the councilors attend this meeting; every other physician in the state is welcome to come and hear the talks on the subjects that are most vital to the medical profession. Every one is welcome and we want you to come.

Dinner will be at six-thirty p. m. This is always free to the presidents and secretaries. Every one else pays one dollar for the meal. If you come you will get more than your money's worth.

The full program of this meeting will be published in the January issue of THE JOURNAL.

Mr. Kingsbury, of the Milbank Foundation, and the believers in state medicine are criticizing the Indiana plan, saying that the set-up in this state has caused the abandonment of the State Board of Health. This is not true. The public health work of the state is in the hands of the medical profession, and it is up to the physicians through their county societies to put this plan across.

One county society in the state already has had two talks on public health (educational) before two service clubs and is planning more talks. That society to date has immunized about 1,500 children under ten years of age against diphtheria, and when the work is finished the physicians will have immunized about 6,000 children in the county, and a great many of these have been vaccinated against smallpox. These are all indigents; the doctors are doing this gratis, and if the work is carefully done any person who can pay will not be able to get this service. This campaign has caused a lot of people who can pay to go to their family physician for this work. There may be a few instances where the people who can pay have slipped it over on the doctors, but they are mighty few. When the work is finished the complete data will be published in this JOURNAL.

Now let Mr. Kingsbury or any one else talk about Indiana not doing its duty in taking care of the health of the people in this state.

In *McCall's Magazine* for November, 1933, is an article on maternal welfare, which indicates that it is designed to further the cause of putting something like Sheppard-Townerism back on the statute books. We in this state and, I believe, the physicians in every state, can take care of the maternal welfare problem without help.

A. M. MITCHELL, *Chairman.*

VOICE OF THE DOCTOR

F. E. R. A.

Albany, N. Y., September 28, 1933.

Dear Mr. Book:

Your recent letter, with regard to regulations for medical relief, addressed to Mr. Hopkins, has been referred to me for reply. I have read over very carefully your program for medical aid, which you have forwarded to all your local relief organizations. It is an admirable statement of a program for "emergency medical aid to the indigent," which has the double merit of establishing a uniform system for providing medical care under reasonable restrictions and yet at the same time it permits of extreme flexibility in its operation. I can well appreciate the tremendous amount of preliminary study and cooperative planning which the Governor's Commission has devoted to the preparation of such a well rounded program.

With respect to points of *policy* I can see no major conflicts between the F. E. R. A. Regulations No. 7 and the program which you have issued. My only preliminary observations in this regard have to do with your statements in instructions Nos. 2 and 3 on the last page of your printed program. I would tentatively suggest that these two paragraphs be revised to read as follows (new matter *italics*, matter to be omitted in parenthesis):

2. "Federal aid money may be used to pay reasonable surgical fees, *for operations performed in the home or in the physician's office*, only for strictly emergency operations."
3. "Federal aid money cannot be used in payment of medical aid wherever a relief agency contracts, *on a salary basis*, with a single physician or a small group of physicians (unless the Governor's Commission has approved such arrangement)."

It seems to me very necessary to require the information which you have indicated as necessary prior to approval of the unit contract basis of payment for medical aid (in the fourth paragraph in your instructions on the last page of your program).

With regard to *procedure* I would suggest that you may find it necessary to amplify or amend some of your statements to make them conform with the general provisions of F. E. R. A. Rules and Regulations No. 7. An example of this would be the addition of the requirement for a written order to both paragraphs of item one on page one of your program.

With regard to *fee schedules* my first impression is that in general they are very fair and reasonable. I would like to have a little more time to study the details of your fee schedule before making a comprehensive criticism of it. I note, for

example, that the recommended fee for poor relief for "reduction of fracture of arm or forearm" is $25.00. There is such a tremendous variation in the extent and severity of such fractures that at the first glance it might seem desirable to have a suggested range for such a procedure, namely, $10.00 to $25.00. Since hospital and institutional services are excluded I think you will find that a great many of the items listed in your fee schedule will be relatively infrequent in occurrence as a charge against federal relief funds.

I note that you have continued the policy—originally adopted by your Governor's Commission—in its medical relief program for Grant County, Indiana, of not circulating the fee list or giving any publicity to the detailed recommendations. After seeing the results of such publicity in certain communities in other states I concur in the recommendation of your State Medical Association in this respect.

I would be very much interested to follow the progress of the development of your general medical program in the various communities of your state. If there is any information at my disposal which will be of service to you, please feel free to call on me.

Very truly yours,
H. JACKSON DAVIS, M. D.,
Consultant in Medical Care, F. E. R. A.

Albany, N. Y., October 16, 1933.

Dear Mr. Book:

Your inquiry with regard to paragraph two on the last page of your program came just as I was leaving for several conferences in Washington. The interpretation of this paragraph which was made here in New York and in Mississippi and a few states that have adopted an emergency medical program on a state-wide basis has been that it means just what it reads, payment for "operations performed in the home or in the physician's office." The term "hospital bills or institutional care," which is excluded as an approved item for payment from federal relief funds, is interpreted to exclude as well the payment of the fee of a surgeon who performs an operation in a hospital.

In regard to the question asked by the Indiana Medical Society, the fees proposed by your Commission are not appreciably lower than those being charged in many other states with federal approval. I talked with Dr. Potter, who is in charge of medical care and hospitalization in the Welfare Department in the State of New Jersey, and although I have not seen the final draft of their new regulations I am quite sure that their charge for an office call does not exceed $1.00. This fee of $1.00 is the maximum charge approved by the State of New York for reimbursement on an office call.

The emergency medical aid program in other states is very restricted in scope in the larger cities where medical aid has customarily been furnished by a city hospital or clinic supported by public funds. In most instances where these larger cities participate at all in this program the only reimbursable item is the billing of prescriptions issued by city physicians on a unit basis so that they can be audited in terms of service to a specific welfare client on a specific date.

Very truly yours,
H. JACKSON DAVIS, M. D.,
Consultant in Medical Care, F. E. R. A.

DEATH NOTICES

FRANK M. PATTON, M. D., of Elkhart, died in a Chicago hospital, October twenty-seventh, after an extended illness. Dr. Patton was thirty-seven years of age. He graduated from Rush Medical College in 1922 and was a member of the Elkhart County Medical Society, the Indiana State Medical Association and the American Medical Association.

F. C. STORY, M. D., of Marion, died in an Indianapolis hospital, October thirtieth, following an illness of several months. Dr. Story graduated from the University of Atlanta, in 1926, and was a member of the Georgia Medical Society. He was a member of the staff of the United States Veterans' Hospital in Grant County.

JOHN HENRY TRENT, M. D., of Marshfield, died October twenty-sixth, aged eighty-six years. He was a graduate of the Long Island College Hospital, Brooklyn, in 1876.

A. E. AYLER, M. D., of Greencastle, died October fourteenth, aged sixty-three years. He graduated from the Atlantic Medical College, Baltimore, in 1897.

HOOSIER NOTES

MEMBERS of the Decatur County Medical Society met at Greensburg, October eighteenth.

DR. C. F. FOX has announced his removal from Garrett, Indiana, to Washington, Indiana.

THE Dearborn-Ohio County Medical Society held its regular monthly meeting at Aurora, November ninth.

THE Marion County Medical Society gave its first bridge party at the Athenaeum, Wednesday evening, November fifteenth.

THE Jay County Medical Society met at Portland, November third, when Dr. Robert M. Moore, of Indianapolis, spoke on "Coronary Occlusion."

DR. HENRY W. SHROCK, of Lagrange, was recently struck by an automobile and sustained a double fracture of the right ankle and body bruises.

DR. FREDERICK A. LOOP has joined his father, Dr. Floyd A. Loop, of Lafayette, in the practice of medicine. Dr. Frederick Loop will limit his practice to general surgery.

DR. L. H. GILMAN, of Indianapolis, presented an illustrated talk before members of the Howard County Medical Society at the Elks Club, November second. His subject was "Encephalitis."

THE regular business meeting of the Miami County Medical Society was held October twenty-eighth at the Dukes Miami County Hospital. Fifteen members attended.

DR. FRED HODGES, of Ann Arbor, and Dr. J. M. Collins, of Indianapolis, were principal speakers before the Muncie Academy of Medicine, November seventh.

THE Third District Medical Society met at the New Albany Country Club, November twenty-second. A report of the meeting and names of officers elected will appear in the January issue of THE JOURNAL.

THE Reed Drug Company, of Anderson, gave its annual party for physicians and their wives at the Anderson Country Club, October eighteenth, in honor of members of the Madison County Medical Society.

THE Northeastern Indiana Academy of Medicine met at the Gawthrop Hotel, Kendallville, October twenty-sixth. Dr. Max M. Peet, of Ann Arbor, Michigan, was the principal speaker.

DR. THURMAN B. RICE, of Indianapolis, spoke on "Sex Education" before members of the Terre Haute Rotary Club and their guests, October thirty-first.

MEMBERS of the Adams County Medical Society met at the Adams County Memorial Hospital, Decatur, November tenth. Dr. Beaumont Cornell, of Fort Wayne, was the principal speaker.

THE Gibson County Medical Society held a dinner meeting at Wheeler's Cafeteria, Princeton, November thirteenth. Dr. F. W. Cregor, of Indianapolis, was the principal speaker.

DR. P. E. MCCOWN and Dr. Larue Carter, both of Indianapolis, were the principal speakers before the Greene County Medical Society at Linton, October twelfth.

MEMBERS of the Porter County Medical Society met at the Lembke Hotel, Valparaiso, October twenty-fourth, to hear Dr. J. R. Phillips, of Michigan City, present a paper on "Recent Advances in Obstetrics." Attendance numbered twenty.

THE EIGHTH DISTRICT MEDICAL SOCIETY will meet in Anderson, December sixth, with sessions beginning at one-thirty. The afternoon will be devoted to the Indiana Plan of Postgraduate Child Welfare problems. Short papers and a number of clinical cases will be shown. In the evening Drs. Kirklin and Mann, of Rochester, Minnesota, will be the principal speakers. Ladies will be entertained by the Anderson members of the Woman's Auxiliary.

All interested physicians are invited to attend.

DR. CYRUS C. STURGIS, of Ann Arbor, Michigan, discussed case presentations of "Anemia" before forty-nine attendants at the November second meeting of the Elkhart County Medical Society. This was a dinner meeting at the Hotel Elkhart.

DR. ROBERT MOORE, of Indianapolis, presented a paper on "Heart Conditions in Hyperthyroidism" before eighteen members of the Parke-Vermillion County Medical Society at the Vermillion County Hospital, October eighteenth.

THE November fourteenth meeting of the Indianapolis Medical Society was held at the Athenaeum; a symposium on gastro-intestinal disorders was presented by Drs. E. F. Kiser, W. S. Owen, and J. A. MacDonald.

THE regular meeting of the Fountain-Warren County Medical Society was held in Attica, November second. Dr. Frank W. Cregor and Dr. John E. Dalton, of Indianapolis, were the principal speakers.

MEMBERS of the Dearborn-Ohio County Medical Society held a dinner meeting at the King Hotel, Lawrenceburg, October twenty-sixth. Dr. Howard L. Stitt, of Cincinnati, presented a paper on "Bronchoscopic Lavage."

DR. A. M. SNELL, of the Mayo Clinic, Rochester, Minnesota, presented an address on "Biliary Diseases" before the Tippecanoe County Medical Society, at Lafayette, October twelfth. Attendance numbered fifty.

DR. J. P. GREENHILL, of Chicago, discussed "Recent Advances in Obstetrics and Gynecology" before twenty-seven attendants at the October nineteenth meeting of the Laporte County Medical Society, in Michigan City.

"FRACTURES of the Lower Extremities" was the subject of a paper presented by Dr. W. D. Inlow before members of the Shelby County Medical Society at Shelbyville, November first. Seventeen physicians attended the meeting.

A NEW wing has been added to the Madison County Tuberculosis hospital, for the use of children. The wing was dedicated October twenty-third. It will accommodate twenty-five patients. The late Norman R. Kettering was the donor of the addition.

THE Carroll County Medical Society held a meeting at Camden, November tenth. Dr. E. E. Padgett, of Indianapolis, presented an address on "Medical Economics." Attendance numbered thirty-eight. A report of the immunization work done in Carroll County was made.

MEMBERS of the Wayne-Union County Medical Society met at the Richmond-Leland Hotel, Richmond, October twelfth, to hear Dr. Edward Markey, of Dayton, Ohio, discuss "Treatment of Incomplete Abortions." Dr. Harry Ross explained the Indiana plan as related to child welfare work.

OFFICERS for 1934 were elected at the October dinner meeting of the Elwood Medical Society, as follows: president, Dr. Floyd Harrold; vice-president, Dr. Ralph Plough; secretary-treasurer, Dr. W. A. Laudeman. An address on "Obstetrics" was read by Dr. Foster J. Hudson, of Indianapolis.

A NOTE concerning receivership of the Physicians Casualty Company, published in the October issue of THE JOURNAL, has caused some confusion in the minds of a few Indiana physicians who have gained the false impression that the Medical Protective Company of Fort Wayne is the company concerned, which is not the case.

AT the November ninth meeting of the Tippecanoe County Medical Society, held in the Purdue Memorial Union Building, Dr. J. J. Callahan, of Chicago, presented a paper on "Shoulder and Knee Injuries." The dinner meeting was preceded by a clinic at St. Elizabeth Hospital. Sixty physicians were present to hear the address.

THE Hancock County Medical Society held its regular meeting at the Columbia Hotel, Greenfield, November thirteenth. A symposium, "Favorite Medical Treatment for Some Common Clinical Conditions," was presented by Drs. R. E. Kinneman, C. H. Bruner, and C. M. Gibbs. Dr. J. R. Woods explained the new immunization program.

THE Jasper-Newton County Medical Society met at the Jasper County Hospital, October twenty-eighth. Dr. J. H. Warvel, of Indianapolis, discussed "Importance of the Laboratory in Diagnosis of Disease." Dr. Harry English was host for the meeting, which was planned to get members acquainted with the new superintendent of the hospital.

MEMBERS of the Posey County Medical Society met at the Tavern Inn, New Harmony, October twenty-sixth. The principal speaker was Dr. W. B. Challman, of Mount Vernon, whose subject was "Anaesthesia by the Closed Method." Attendance numbered thirteen. At this meeting the members voted to hold monthly meetings the second Thursday of each month.

THE 131st semi-annual meeting of the Union District Medical Association was held in Brookville, Indiana, October twenty-sixth, with thirty physicians in attendance. Dr. P. S. Johnson, of Richmond, is the president for the 1933-1934 season. Papers were presented by Drs. V. C. Griffis, of Richmond, C. E. Wooding, of Cincinnati, and William Muhlberg, of Cincinnati.

DR. NORMAN E. JOBES has been made president of the executive staff of the Indianapolis City Hospital, Dr. C. J. Clark, vice-president, and Dr. David H. Sluss, secretary. Those elected to service were Dr. Leon Zerfas, Dr. Henry S. Leonard, Dr. H. F. Beckman, Dr. C. H. McCaskey, Dr. Leonard Ensminger, Dr. Larue Carter, Dr. J. C. Carter, Dr. Bernard Larkin, and Dr. William Tinney.

THE fiftieth semi-annual meeting of the Eleventh District Medical Association was held at Manchester College, North Manchester, October twenty-fifth. Speakers were N. C. Gilbert, M. D., Chicago; Thomas D. Allen, M. D., Chicago; Earl Palmer, M. D., Logansport; Professor J. R. Schutz, of North Manchester, and Louis H. Segar, M. D., Indianapolis. A clinic composed the morning program.

DURING 1932 the Rockefeller Foundation appropriated $11,577,064 for projects in the fields of the medical, social, and natural sciences, the humanities, and public health. For public health work the Foundation expended during the year the sum of $2,539,057.15. The largest appropriation of the year in the medical sciences, $1,282,652, was made to McGill University, Montreal, Canada, for the establishment of a neurological institute.

THE Elkhart County Medical Society has announced its program for the 1933-1934 season with meetings on December seventh, January fourth, February first, March first, April fifth, and May third. The May third meeting will be held in Goshen, all others in Elkhart. Speakers will include Dr. William J. Butler, of Grand Rapids, Michigan; Dr. O. R. Yoder, Ypsilanti, Michigan; Dr. Joseph L. Baer, Chicago; Dr. J. L. Miller, Chicago; and Dr. Matthew Winters, Indianapolis.

THE November seventh meeting of the Fort Wayne Medical Society was held at the Lutheran Hospital with clinical case presentations by staff members comprising the program. On November twenty-first Dr. H. F. Thurston, of Indianapolis, talked on "Blood Vessel Surgery." Mr. G. F. Peabody, of South Whitley, will discuss "Nostrums and Quacks" at the December fifth meeting of the society, and on December nineteenth Dr. L. J. Pollock, of Northwestern University, will discuss "Common Findings in Neurological Cases."

A BEACON light has been erected on the Indianapolis Methodist Hospital, and it is said to be the first hospital beacon in the United States. Dedication ceremonies were held November ninth. On a clear night the beacon light may be seen within a radius of fifty miles. It stands eighty feet above the roof of the hospital, and 285 feet above the ground. The light is in the figure of a white cross. A contract between the hospital and the Federal government states that the light will never be allowed to go out during hours of darkness, in order that aviators may not be misled.

MEMBERS of the Vigo County Medical Society met at St. Anthony's Hospital, Terre Haute, November seventh, to hear Dr. L. Siebenmorgan talk about "Growth and Body Mechanics" and to see a case presented by Dr. E. C. McBride with fracture of the fourth and fifth cervical vertebrae. Attendance numbered thirty-nine. At the October tenth meeting of this society Dr. M. C. Topping presented a case with fracture of the femur; Dr. A. M. Mitchell presented a case with fracture of the first and second cervical vertebrae with reduction, and Dr. F. E. Sayers presented a paper on "Coronary Occlusion."

THE Tumor Clinic of the Michael Reese Hospital is conducting a clinical investigation on the treatment of a special group of neoplasms by means of massive radium therapy and will be glad to accept free of charge a limited group of indigent patients suffering from these conditions. The tumors under investigation are cancer of the tonsil, pharynx, larynx, and prostate; also benign prostatic hypertrophy occurring in patients in whom operation is contra-indicated. It is essential that these patients should not have received any previous radiation treatment. It is requested that the referring physician submit data concerning case before sending the patient.

THE Carroll County Postgraduate Pediatric Course was presented November twentieth to twenty-fourth, with the assistance of the Cass County Medical Society. Programs were arranged for evenings only, and were presented at Delphi, Logansport, and Flora. Speakers were Drs. Murray N. Hadley, George S. Bond, Herbert Call, Lyman T. Meiks, James H. Stygall, Howard Mettel, James Carter, Byron Rust, H. O. Mertz, Frank Gastineau, and John H. Warvel, all of Indianapolis. The series of lectures was conducted as a part of the Indiana Plan of Child Health and Maternal Welfare as set out by the Indiana Department of Public Health.

THE Indiana Society for Mental Hygiene will hold its eighteenth annual meeting December fourth in Indianapolis. Donald DuShane, of Columbus, is president of this society and Dr. Hazel Hansford, of Madison State Hospital, is secretary. Physicians are invited to attend the sessions, which will begin at nine-thirty in the morning. Speakers will include Dr. Olga Hoffman, of Madison; Dr. Charles P. Emerson, of Indianapolis; Dr. L. P. Harshman, of Fort Wayne; Dr. Spafford Ackerly, of Louisville; Mrs. Ruth Heavenridge, of Indianapolis; Professor M. L. Entorf, of Hanover; Mr. Edward E. DiBella, of the Governor's Commission on Unemployment Relief, Indianapolis, and Dr. Louis A. Lurie, of Cincinnati.

THE annual postgraduate course given by the Indiana University School of Medicine is being planned to offer a comprehensive review of recent developments in medicine. Addresses on the more important subjects will be given by guest speakers of national reputation. A new and original method for the presentation of the best in diagnosis, prognosis, and treatment is now being worked upon. During the first week it is planned to increase the number of clinical demonstrations emphasizing the practical application of newer diagnostic and treatment methods. The clinical week will offer more detailed instruction at the bedside and in the laboratory for those desiring it. Further details will be announced later. Watch for them.

THE American Association for the Study of Goiter for the fifth time is offering three hundred dollars as a first award and two honorable mentions for the best essays based upon original research work on any phase of goiter presented at the annual meeting in Cleveland, Ohio, June 7, 8, and 9, 1934. Competing manuscripts must be in English and submitted to the corresponding secretary, J. R. Yung, M. D., 670 Cherry Street, Terre Haute, Indiana, not later than April 1, 1934. The first award at the 1933 meeting was given Anne B. Heyman, A. B., M. S., Ann Arbor, Michigan, for her essay, "The Bacteriology of Goiter and the Production of Thyroid Hyperplasia in Rabbits on a Special Diet." J. Lerman, M. D., and W. T. Salter, M. D. (an essay prepared jointly), Boston, Massachusetts, and Prof. Dr. Stefan Konsuloff, of Bulgaria, received honorable mention.

DR. WALTER PORTTEUS, of Franklin, was elected president of the Seventh District Medical Society at the annual meeting in Plainfield, October twentieth. Dr. Thomas B. Barker, of Danville, was made vice-president; and Dr. Gordon W. Batman, of Indianapolis, was made secretary-treasurer. The honor guest at this meeting was Dr. Plinn F. Morse, of Detroit, who presented a paper on "Parathyroid In Its Relation to Clinical Medicine." Other speakers were Dr. T. J. Beasley, president for 1933, Dr. E. R. Royer, of North Salem, Dr. H. M. Banks, Dr. P. E. McCown, Dr. G. F. Bond, and Dr. P. J. Fouts, all of Indianapolis. Officers for 1933 were Dr. T. J. Beasley, Indianapolis, president; Dr. Edward M. Pitkin, Martinsville, vice-president; Dr. L. A. Ensminger, Indianapolis, councilor; and Dr. W. L. Portteus, Franklin, secretary-treasurer. The 1934 meeting will be held in Martinsville.

THE Wabash County Postgraduate Pediatric Course was presented November twentieth to twenty-fourth, in the Town Hall, at North Manchester. The Huntington, Whitley, and Kosciusko county societies assisted. The series of lectures was a part of the Indiana plan of Child health and maternal welfare as set out by the Indiana Department of Public Health. Programs were in the evenings only and included the following subjects: "Tuberculosis and Other Chronic Pulmonary Diseases in Childhood," by Dr. Robert B. Sanderson, of South Bend; "The Acute Respiratory Diseases of Childhood," by Dr. O. N. Torian, Indianapolis; "The Feeding of Children," by Dr. Matthew Winters, Indianapolis; "The Gastro-Intestinal Diseases of Childhood," by Dr. Ernest R. Carlo, Fort Wayne; "The Genito-Urinary Diseases of Childhood," by Dr. H. O. Mertz, Indianapolis; "Syphilis and the Skin Diseases of Childhood," by Dr. Frank Gastineau, Indianapolis; "Blood Diseases of Childhood," by Dr. John H. Warvel, Indianapolis; "Juvenile Diabetes," by Dr. C. L. Rudesill, Indianapolis; "Contagious Diseases of Children," by Dr. Russell Hippensteel, Indianapolis; "Surgical Diagnosis in Children," by Dr. Dale Pyle, South Bend; and "Heart Disease in Children," by Dr. George S. Bond, Indianapolis.

In addition to the articles already enumerated the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

Abbott Laboratories:
- Abbott's Haliver Oil, Plain.
- Chloriodized Rapeseed Oil:
 - Ampules Campiodol Emulsion, 20 cc.
- Capsules Ephedrine Sulphate-Abbott, 3/8 grain.
- Capsules Ephedrine Sulphate-Abbott, 1/2 grain.
- Capsules Ephedrine Sulphate-Abbott, 3/4 grain.
- Solution Ephedrine Sulphate-Abbott, 3%.

Gilliland Laboratories:
- Staphylococcus Vaccine (Albus and Aureus), 5 cc. vial.

Adolphe Hurst & Co.:
- Metaphyllin:
 - Ampules Solution Metaphyllin, 0.24 Gm., 10 cc.
 - Ampules Solution Metaphyllin, 0.48 Gm., 2 cc.
 - Suppositories Metaphyllin, 0.36 Gm.
 - Tablets Metaphyllin, 0.1 Gm.

Lederle Laboratories, Inc.:
- Fish Glue Allergenic Extract (Lederle).
- Tuberculin "O. T." (Old Tuberculin), 1 cc. vial package.

Mead Johnson & Co.:
- Mead's Halibut Liver Oil.
- Mead's Halibut Liver Oil with Viosterol, 250 D.

National Drug Co.—
- Gas Gangrene Antitoxin, Refined and Concentrated.
- Tetanus-Perfringens Antitoxin, Refined and Concentrated.
- Erysipelas Antistreptococcus Serum.
- Tuberculin Serial Dilutions (O-T) (Human Type).
- Schick Test Control.

Parke, Davis & Co.:
- Parke-Davis Haliver Oil, Plain.

Petrolagar Laboratories:
- Petrolagar (with Cascara, Non-Bitter).

Pharmedic Corporation:
- Aminophylline-Pharmedic:
 - Ampules Solution Aminophylline-Pharmedic, 0.24 Gm., 10 cc.
 - Ampules Solution Aminophylline-Pharmedic, 0.48 Gm., 2 cc.
 - Suppositories Aminophylline-Pharmedic, 0.36 Gm.
 - Tablets Aminophylline-Pharmedic, 0.1 Gm.

Radium Chemical Co.:
- Radium Chloride-Radium Belge.

G. D. Searle & Co.:
Aminophylline-Searle:
Ampules Solution Aminophylline-Searle, 0.24 Gm., 10 cc.
Ampules Solution Aminophylline-Searle, 0.48 Gm., 2 cc.
Tablets Aminophylline-Searle, 0.1 Gm. (1½ grains).

Smith, Kline & French Laboratories:
Benzedrine:
Benzedrine Inhaler.
Benzedrine Solution.

E. R. Squibb & Sons:
Autolyzed Liver Concencrate-Squibb.
False Ragweeds Combined Pollen Allergen Solution-Squibb (False Ragweed and Slender Ragweed in equal parts); Orachs (Shadscale) Pollen Allergen Solution-Squibb (Shadscale, Redscale and Wingscale in equal parts); Oregon Ash Pollen Allergen Solution-Squibb; Ragweed Combined Pollen Allergen Solution-Squibb (Giant Ragweed and Dwarf Ragweed in equal parts); Rye Grasses Combined Pollen Allergen Solution-Squibb (Perennial Rye Grass and Italian Rye Grass in equal parts); Sagebrush Combined Pollen Allergen Solution-Squibb (Sagebrush and Pasture Sage in equal parts); Wormwoods Combined Pollen Allergen Solution-Squibb (Biennial Wormwood, Dragon Sagewort, Dark-Leaved Mugwort, and Mugwort in equal parts).
Squibb Stabilized Refined Halibut-Liver Oil.
Squibb Stabilized Refined Halibut-Liver Oil with Viosterol, 250 D.

The following products have been included in the list of articles and brands accepted by the Council but not described in N. N. R. (New and Non-Official Remedies, 1933, p. 437):

Lederle Laboratories, Inc.:
Fish Glue Allergenic Extract Glycerinated (Lederle).

Merck & Co., Inc.—
Guaiacol Carbonate-Merck.

INDIANA UNIVERSITY NEWS NOTES

GUSTAVUS A. PETERS, graduate student and instructor in the Indiana University School of Medicine at Bloomington, has been selected as one of the three students chosen as the university's candidates for the Rhodes scholarship. Along with Peters those chosen are Robert Cavanaugh, Indianapolis, and Edward Schrader, Kokomo. These students will appear before the State Rhodes Scholarship Selection Committee the first part of January. Students from other universities and colleges of the state also will appear at this time before the state committee. Two students will be selected to represent the state before the district committee on Rhodes scholarships to be held in January at Chicago. Peters was awarded the A. B. degree with high distinction from Indiana University in 1932. He is a member of the Phi Chi professional medical fraternity and the Phi Beta Kappa national scholastic fraternity. He recently was elected to membership in the Indiana Academy of Science.

DR. WILL SCOTT, of the Indiana University Zoology Department; John M. Burgin, assistant in the I. U. Physiology Department; Benjamin Speheger, anatomy assistant, and Mitchell Taylor, president of the Phi Beta Pi national professional medical fraternity at Bloomington, spoke early in November before an informal dinner meeting of the Phi Beta Pi Fraternity. The dinner was held in the Union Building at Bloomington. Twenty members of the chapter in the Indianapolis division of the I. U. medical center attended the meeting.

WOMAN'S AUXILIARY

On October 20th, at the invitation of Dr. Padgett and Dr. Beasley, Mrs. Tomlin and other members of the Indianapolis Medical Society assisted in the organization of an auxiliary to the Seventh District Medical Society at Plainfield. The women were entertained by a trip through the Boys' School, followed by a tea given by Dr. and Mrs. Dill in their home. In the evening they were guests at dinner and entertained in the high school. Mrs. Scamahorn, of Pittsboro, was elected president; Mrs. Portteus, of Franklin, vice-president, and Mrs. Welcher, of Indianapolis, secretary-treasurer.

The Indianapolis Auxiliary entertained with a tea for visiting delegates to the American Health Nursing Association on Monday afternoon, October 9. The tea was held in Sculpture Court of the John Herron Art Institute. A musical program by Miss Fanny Kiser preceded the travel talk by Dr. Charles P. Emerson. Mrs. Kearby, Mrs. Beckman, Mrs. Dunning, and their committees had charge of the affair.

BOOK REVIEWS

BOOKS RECEIVED

A TEXT-BOOK OF MEDICINE. (By 141 American Authors) Edited by Russell L. Cecil, A. B., M. D., Sc. D., Professor of Clinical Medicine, Cornell University, Medical College; Associate Attending Physician, New York Hospital, New York City. And Associate Editor for Diseases of the Nervous System, Foster Kennedy, M. D., F. R. S. E., Professor of Neurology, Cornell University, Medical College; Director, Department of Neurology, Bellevue Hospital, New York City. Third edition, revised and entirely reset. 1664 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1933. Cloth, $9.00 net.

SOCIETIES AND INSTITUTIONS

INDIANA STATE MEDICAL ASSOCIATION

EXECUTIVE COMMITTEE

October 24, 1933.

Meeting called to order at 2:15 p. m.

Roll call showed the following present: W. H. Kennedy, M. D., chairman; H. H. Wheeler, M. D.; J. H. Weinstein, M. D.; O. O. Alexander, M. D.; E. E. Padgett, M. D.; A. F. Weyerbacher, M. D.; Albert Stump, attorney, and T. A. Hendricks, executive secretary. Guests: V. K. Harvey, M. D., and Ernest Rupel, M. D., of the State Department of Public Health.

MEMBERSHIP REPORT

Number of members on September 30, 1933	2,626
Number of members on September 30, 1932	2,707
Loss over last year	81
Number of members on October 24, 1933	2,637
Number of members on October 24, 1932	2,710
Loss over last year	73
Number of members on December 31, 1932	2,724

1933 CONVENTION, FRENCH LICK

(1) *Report on sale of exhibit space:*

12 booths and 2 table spaces sold

Amount due	$870.00
Cash received to date	837.50
Amount outstanding	$ 32.50

(2) *Financial Report:*

RECEIPTS

Commercial exhibit	$870.00

EXPENDITURES

	Expenses	Budget	Inc. or Dec.	
Expenses of speakers	$ 150.85	$ 200.00	Dec.	$ 49.15
Booths and signs	15.85	150.00	Dec.	134.15
Programs and printing	232.50	125.00	Inc.	107.50
Badges	80.59	80.00	Inc.	.59
Exhibit circulars	21.50	10.00	Inc.	11.50
Headquarters traveling and hotel expenses	125.36	150.00	Dec.	24.64
Entertainment	500.00	500.00		
House of Delegates breakfast	3.00		Inc.	3.00
Scientific exhibit		150.00	Dec.	150.00
Miscellaneous (registration girls)	35.00	50.00	Dec.	15.00
Total	$1,164.65	$1,415.00	Dec.	$250.35
Reporters (JOURNAL charge)	$ 216.55	$ 290.00	Dec.	$ 73.45

(3) *Resolutions, motions, and recommendations adopted at French Lick and referred to Executive Committee for action:*

(a) *Resolution of Health Insurance Committee* passed by the House of Delegates providing that "any member who takes part in an organization of the health insurance type which is not approved by the Executive Committee of the Indiana State Medical Association shall be automatically suspended from membership in his county medical society and the Indiana State Medical Association, and cannot be reinstated until he severs his connection with the organization which is not approved."

The Executive Committee recommended a statement in THE JOURNAL that it was the intent of the House of Delegates when this resolution was passed that it should be adopted by each county medical society, the name of the State Association being omitted and that of each county society being used instead.

Information received that Marion County has adopted such a resolution.

(b) *Codification of Constitution and By-Laws.* Dr. Weinstein, president, made the suggestion at the meeting of the House of Delegates that there is a real necessity for the codification of the Constitution and By-Laws. He stated, "We have gone on for a number of years with a number of new resolutions and by-laws being passed. There are some mix-ups and some discrepancies. I would like to have a motion made that the Constitution and By-Laws be codified and printed." This motion was carried.

The Executive Committee instructed the executive secretary to study the minutes of the House of Delegates in order that a preliminary report upon this might be made at a future meeting of the Executive Committee.

(c) *Combined audit of Association and Journal books.* The report of the treasurer which was adopted by the House of Delegates suggests that a combined audit of the Association affairs and THE JOURNAL be made as of December 31 each year to eliminate the present necessity of having a double audit. The reference committee upon the reports of officers to which the treasurer's report was referred recommended that "the books of the Association be closed on December 31 and a full report of the Association and JOURNAL affairs can be made at each annual meeting as of that date."

(d) *Recommendation of the reference committee in regard to charges against the medical defense fund.* The reference committee to which the report of the Committee on Special Medical Defense Fund was referred made the following suggestions:

1. The proposal that the Special Defense Funds be kept as a separate fund is in line with the present provision of the by-laws. We are informed that the moneys in question are so kept by our treasurer, Dr. Weyerbacher.

2. The reference committee is of the opinion that it would be inadvisable for the State Association to assume indemnity liability. Such an effort would put the Association in the insurance business and subject to the supervision of the Insurance Department of the state. It would make the Association subject to taxes which it is not under the present plan.

3. The committee feels, however, that it would not be improper for the Defense Fund to carry its proper share of administrative expense. This, we understand, has not been the policy in the past and accounts in part for the size of the present sum now carried as medical defense fund and surplus.

The reference committee recommends that the present plan of operation of the medical defense provisions of our by-laws be continued without change.

In line with the third suggestion Dr. Weinstein made a motion which was seconded by Dr. Wheeler that the entire amount of the per diem paid the attorney of the Association and the prorated share of the administrative expenses of the office be charged against the medical defense fund. Motion carried. The treasurer was instructed to charge the postage, stationery, deposit box rental, bond, etc., that is used for medical defense activities against the medical defense fund.

(e) *Excerpt from Dr. Weinstein's address in regard to University Hospitals:*

> "I take the liberty of quoting again one of our ex-presidents, Dr. Crockett, who said in his presidential address, 'Conduct of the medical school and hospitals should be such as to keep the state free from competition with the private practitioner. Considerable irritation has been voiced by certain of our members in the past over regulations which permitted the state, through state owned and operated hospitals, what seemed to be competition with the doctor in private practice. As long as such incidents occur, closer cooperation between the medical school and the State Association will be increasingly difficult. Teaching material only should be admitted to the medical school hospitals. Admission of pay patients places the state in competition with the private practitioners and community hospitals.'"

There is no action to be taken upon this by the Executive Committee but this is to be passed on to Dr. Padgett.

(4) *Alternates to the A. M. A.* Although the House of Delegates switched the order in the nominations of alternates, it is felt that the same alternates should serve for the same delegates for the next two years as in the past year.

1934 CONVENTION, INDIANAPOLIS

(1) *Date.* Resolution passed at French Lick empowering the Executive Committee to change the date of the annual session so that it avoids conflict with any special national society meet-

ings and so as to avoid the late September heat that has characterized recent meetings. The secretary has obtained a list of these national meetings and a definite date is to be set at the November meeting of the Executive Committee.

(2) *Indiana health round-up at the time of the state meeting next October.* Idea would be to have the state health officers, postgraduate meeting, Nurses' Association, Tuberculosis Association, Cancer Society and other groups hold their annual meetings in Indianapolis at that time and have one day in the program devoted to subjects on public health in which all groups would be interested. Dr. Harvey said that he felt sure the health officers would be glad to have a meeting coinciding with the state meeting in Indianapolis.

Midwinter Council Meeting

Sunday, January 14, 10:00 a. m., set for midwinter Council meeting. This will be far enough after the first of the year to give complete audit of the books of the Association and THE JOURNAL. The Budget Committee is to meet directly after the adjournment of the Council.

Secretaries' Conference

Date set for Sunday, January 21, 1934. The following speakers have been invited to attend:

W. W. Bauer, M. D., director, Bureau of Health and Public Instruction, American Medical Association, Chicago.
N. B. VanEtten, M. D., New York City.
Haven Emerson, M. D., New York City.
J. Jackson Davis, M. D., Consultant in Medical Care, F. E. R. A., Albany, New York.

Separate Board Advocated by Chiropractors

Attention of the committee called to the newspaper articles telling of the attempt that will be made at the next session of the legislature by the chiropractors to have a separate board.

What Is a Clinic?

Dr. O. O. Alexander to prepare article upon this subject to be submitted to the editor of THE JOURNAL.

Indigent Sick

(1) *Indiana plan for the use of Federal Emergency Relief Act funds.* Letters received from the following state medical societies thanking the Executive Committee for sending a copy of the Indiana plan to them and many of them stating that Indiana probably had done more than any other state in perfecting a simple and workable plan:

Arizona State Medical Association
Medical Society of the District of Columbia
Louisiana State Medical Society
New Orleans *Medical and Surgical Journal*
Massachusetts Medical Society
New Hampshire Medical Society
North Dakota State Medical Association
Pennsylvania *Medical Journal*
State Medical Association of Texas
Medical Society of Virginia
West Virginia *Medical Journal*

Many states asked for amplifying information concerning these plans.

(2) *Letters to Mr. Book from H. Jackson Davis, M. D., Consultant in Medical Care, F. E. R. A.* These letters are to be carried in the December number of THE JOURNAL. Answer, complaining against the ruling made by the F. E. R. A. that federal funds shall not be paid for services rendered in hospitals, made to Dr. Davis' letter by Dr. Weinstein and signed by officers of the Association.

(3) Action taken by Fort Wayne Medical Society in regard to indigent work brought to the attention of the committee.

(4) Letter from Dr. Leland, director of the Bureau of Medical Economics, asking secretaries of all county medical societies for information and documents that are available in regard to the plans and agreements that are worked out by the local Federal Emergency Relief Administration agents, brought to the attention of the committee. The secretary was instructed to get notices out to the county society secretaries asking them to send any information they might have to Dr. Leland. The secretary said that copies of agreements and all work done by the Association up to this time had been sent to Dr. Leland.

Health Officers' Reports

Suggestion was made at the last meeting that health officers of each county make a report to their county medical society each year. Dr. Harvey presented a list of state health officers of which 154 are laymen. The Executive Committee said that something should be done to impress upon the public the necessity of having a well-trained medical man as health officer. This was to come up at the next meeting of the Executive Committee.

Gross Income Tax Statistics

Letter received from C. A. Jackson, director of the Gross Income Tax Division, State of Indiana, stating that statistical information in regard to gross income tax paid by the physicians of the state might be available if it were desired. The Executive Committee instructed the secretary to inquire of Mr. Jackson if the committee could have the gross income tax paid by physicians of the state and the average per capita tax paid by those making returns as compared with the average per capita tax paid by the physicians. He was also to obtain information as to the number of physicians reporting.

Survey of Medical Facilities in Indiana

Letter from W. W. Patty, director of the Physical Welfare Training Department of Indiana University, and a suggested plan for a survey of medical facilities in Indiana, brought to the attention of the Executive Committee. The committee instructed the secretary to invite Mr. Patty to the next meeting of the committee to discuss this matter and assigned the suggested plan of survey to Dr. A. G. Cavins of Terre Haute for comments and criticisms. The thought of the committee was that something worthwhile might be done along this line if a sensible and not too complicated questionnaire were sent out to the physicians.

Full-time Medical Coordinator for Indiana

The Executive Committee suggested to Dr. Harvey that it thought it would be to the best interests of the public, the medical profession, and the State Department of Public Health, if a full-time man were assigned by the State Department of Public Health to act as a medical coordinator to aid the county medical societies and local welfare organizations in carrying on campaigns in child hygiene work and in the proposed statewide diphtheria immunization campaign. Both Dr. Harvey and Dr. Rupel said that they thought such a coordinator is necessary if the full benefit of such a campaign is to be obtained.

Councilor District Meetings

A plan was suggested by the Executive Committee that each councilor call a meeting of the presidents and secretaries of the county medical societies in his district. To this meeting are to be invited the members of each county society health or immunization committee, if such has been appointed, and the district chairmen appointed by Dr. Torian's committee. The complete subject of immunization is to be brought up and definite plans outlined as to how each society is to take part in this work. Talks are to be made at this meeting in regard to this campaign by Dr. Harvey, when possible. The medical coordinator is to attend all these meetings and is to give the details of the plan so work may be started immediately in each county society to carry this campaign into effect.

Virginia Postgraduate Course Plan

A program of the postgraduate course in prenatal and postnatal care that is being carried on in Virginia was brought to the attention of the committee. Copies of this program were to be sent to Dr. A. M. Mendenhall and to Dr. W. D. Gatch.

The Journal

(1) Contract with editor. Albert Stump is to prepare a contract to be signed by E. M. Shanklin, M. D., editor of THE JOURNAL beginning January 1, 1934, to January 1, 1935. This was ordered by the Council.

(2) Size of THE JOURNAL. The Executive Committee ordered that THE JOURNAL be maintained this year the same size as in former years. With this in mind the following statistics were presented:

Pages in JOURNAL, 1933

	Reading	Total Reading	Advertising
January	50	50	30
February	46	96	30
March	50	146	30
April	62	208	30
May	50	258	30
June	46	304	30
July	52	356	28
August	48	404	28
September	98	502	30
October	42	544	30
November	46	590	30
Total pages through November, 1933			916

With the November issue ten more reading pages will have been published than were printed last year. With an ordinary size December issue the reading pages will exceed the number published in any year since THE JOURNAL was established, with one exception, 1930, when 708 pages were printed. Ad pages number a little more than one-half the number in 1930. If the same type had been used this year as last, approximately 750 pages would have been required to print the material that has been carried this year; thus, THE JOURNAL really has exceeded *any* year as to the amount of material printed.

(3) Suggested letter to be sent to commercial advertisers and to professional card accounts approved by the Executive Committee.

INDIANA STATE MEDICAL ASSOCIATION
BUREAU OF PUBLICITY

September 8, 1933.

Meeting called to order at 4:00 p. m.

Present: William N. Wishard, M. D., chairman; E. D. Clark, M. D., and T. A. Hendricks, executive secretary.

Minutes of the meeting of August 31 read and approved for signature at the next meeting.

Article prepared for Parent-Teacher Bulletin approved by Bureau.

Request for speaker:

September 20—Parke-Vermillion County Medical Society, Clinton, Indiana. 7 o'clock dinner. 8 p. m., talk before doctors and laity. Speaker obtained.

Medical meeting:

September 13—Second District Medical Society, Bloomington, Ind.

The historian of the Association appeared before the Bureau of Publicity and outlined at length the work he has done in collecting material for his project. His report was most interesting and the Bureau hopes that within the next few months an introductory article prepared by the historian may be ready for publication in THE JOURNAL. The Bureau will be most pleased to receive any medical historical material that is available in any part of the state.

* * *

September 15, 1933.

Meeting called to order at 4:00 p. m.

Present: William N. Wishard, M. D., chairman; J. H. Stygall, M. D.; E. D. Clark, M. D., and T. A. Hendricks, executive secretary.

A schedule for publicity on the annual session of the Indiana State Medical Association at French Lick was approved by the Bureau.

Report on medical meeting:

September 13—Second District Medical Society, Bloomington, Ind. Dinner and lay meeting. 150 present at lay meeting for a discussion of child welfare.

The executive secretary outlined the arrangements he had made to handle the publicity for the American Public Health Association meeting to be held in Indianapolis the second week in October.

The Bureau instructed the secretary to purchase the book published by the American Medical Association entitled, "What to Tell the Public about Health."

October 17, 1933.

Meeting called to order at 3:30 p. m.

Present: William N. Wishard, M. D., chairman; E. D. Clark, M. D.; J. H. Stygall, M. D.; and T. A. Hendricks, executive secretary.

Release for publication in Saturday morning papers, October 21,, "A Word to Hunters," read and approved.

Request for speaker:

November 2—Clinton County Medical Society, Frankfort, Indiana. Physicians, dentists, attorneys and laity invited. 5:30 p. m. Subjects: "Unemployment Relief." State director of unemployment relief requested and obtained.

The secretary reported that the publicity for the American Public Health Association meeting was considered by the officers of that organization as having been well taken care of.

The Bureau reviewed the first article which it prepared for the Indiana Parent-Teacher. The following letter was received from Mrs. W. J. Hockett, president of the Indiana Congress of Parents and Teachers, in regard to the material that is supplied by the Bureau for this bulletin:

"No doubt by this time you have seen the copy of the Indiana Parent-Teacher with your splendid contribution filling one of its pages. We are most appreciative for this splendid cooperation of the Indiana State Medical Association. I feel personally that your articles carried in this printed bulletin are going to be one of the most read pages from month to month. I think that it will prove to be of inestimable value to our thousands of lay members. Your first article has been presented in such a friendly and practical way that I am certain that it will catch a responsive feeling right from the first article."

Suggestion made that pictures of all past presidents of the Indiana State Medical Association be obtained for the headquarters office. The Bureau instructed the executive secretary to correspond with the historian and solicit his aid in obtaining these pictures.

The following references to the work of the Bureau of Publicity were made at the annual meeting of the State Association:

(1) President's comment in regard to use of speakers' names in radio broadcasts:

"My attention has been attracted by the number of physicians' names published in newspapers as having talked to civic clubs and lay organizations. Also in radio talks the speaker's name is too frequently mentioned. Even though the talks are sponsored by the local medical society, the Bureau of Publicity ruled in 1929 as follows: The Bureau has adopted a rule that no physician who is in private practice should have his name mentioned in connection with any publicity. The practice of having individual names mentioned in such efforts completely disrupted the Bureau in California several years ago, and was the cause of bitter argument and a split in the St. Louis Society; therefore, the advisability of following the Bureau's rule is heartily endorsed by your officers, and I earnestly request its closer observance in the future."

(Rules of the Bureau have several times been approved by the House of Delegates.)

(2) Recommendation of the Special Committee on Lye Burns that an appropriation of $150.00 be made for printing educational pamphlet upon this subject approved by the House of Delegates:

"Your committee recommends to the Bureau of Publicity that an appropriation of one hundred fifty dollars be made for printing an educational pamphlet for lay consumption to be distributed through the various Parent-Teacher or similar organizations."

The secretary was instructed to write the chairman of the special committee, asking him for an interpretation of what should be placed in this pamphlet.

(3) Report of reference committee upon the annual report of the Bureau of Publicity:

"Your reference committee on publicity wishes to make the following report:

"First, we concur in the report of the Bureau of Publicity and recommend the adoption as published. No group of men in the Association devote as much time to their work as the

members of this Bureau, spending one afternoon of every week, and yet we as delegates scarcely take the time to read in detail the fourteen pages of the report. What other activity of our Association ranks any ways nears in attracting the attention and envy of the other constituent state units of the American Medical Association? If not the pioneer, it is the model for the nation. Our gratitude has been expressed in glowing terms each year of its existence and no further words could add to our indebtedness. We can only give devout thanks to a kind Providence that has extended the life of Dr. W. N. Wishard so that he and Dr. Clark and Dr. Stygall could round out another year of fruit-bearing endeavor. May we again urge every member to cooperate in keeping our publicity on a high ethical plane, and particularly in submerging all personal mention in radio releases?"

Attention of the Bureau of Publicity brought to the fact that about 8,000 "Prevention of Contagious Diseases" pamphlets are still on hand for distribution. The Bureau suggested that these 8,000 pamphlets be distributed despite the fact that one physician has criticised the conservative statement in regard to scarlet fever immunization which appeared in the pamphlet.

The Bureau of Publicity instructed the secretary to inquire of the American Medical Association in regard to broadcasting rules, particularly in regard to the use of an individual practicing physician's name over the radio and publishing such articles in local newspapers with the author's name.

Complaint made to Bureau of Publicity that a tuberculosis cure of doubtful value is being given by a certain so-called clinic in Indianapolis. The secretary was instructed to take this matter up with the Better Business Bureau and with the State Board of Medical Registration and Examination.

There being no further business the meeting was adjourned.

* * *

October 27, 1933.

Meeting called to order at 3:30 p. m.

Present: William N. Wishard, M. D., chairman; J. H. Stygall, M. D.; E. D. Clark, M. D., and T. A. Hendricks, executive secretary.

Release for publication in Saturday afternoon papers, November 4, "State-Wide Immunization Campaign Against Diphtheria," read and approved.

Radio releases:

Saturday, September 9—"High Blood Pressure."
Saturday, September 16—"Competitive Athletics."
Saturday, September 23—"Hoosierland's Health Harvest."
Saturday, October 21—"Ventilation."

Radio releases supplied by the American Medical Association to be brought up for approval of Bureau at next meeting.

Letter written to the historian brought to the attention of the Bureau in regard to pictures of past presidents. The secretary was instructed to write the historian that a number of the pictures of past presidents of the Indiana State Medical Association were carried in Dr. G. W. H. Kemper's "Medical History of Indiana."

Letter written by the secretary to the director of the Bureau of Health and Public Instruction of the American Medical Association asking for information in regard to the rules concerning radio broadcasts, brought to the attention of the Bureau. The Bureau instructed the secretary to write an additional letter stating that the House of Delegates had gone on record several times approving the rules concerning radio broadcasts laid down by the Bureau.

Copy of a letter written to the chairman of the Committee on Lye Burns brought to the attention of the Bureau.

There being no further business the meeting was adjourned. who are concerned in the poor relief program.

INDIANA DIVISION OF PUBLIC HEALTH
BUREAU OF COMMUNICABLE DISEASES
Monthly Report, October, 1933

The current prevalence of the principal communicable diseases, as reported to this bureau by the state health authorities, shows a marked increase, except typhoid fever and whooping cough. There were 1,591 communicable diseases reported during October, all counties submitting either positive or negative reports.

A summary of the diseases from the urban and rural populations is given below:

Diseases	Total	Urban	Rural
Tuberculosis	168	99	69
Chickenpox	178	83	95
Measles	28	24	4
Scarlet Fever	549	223	326
Typhoid Fever	53	13	40
Whooping Cough	62	36	26
Diphtheria	335	128	207
Influenza	163	5	158
Pneumonia	12	3	9
Mumps	3	1	2
Poliomyelitis	4	3	1
Meningitis	9	8	1
Encephalitis Lethargiea	4	2	2
Undulant Fever	1	1	0
Smallpox	3	1	2

DIPHTHERIA. Over 50% increase was noted in the number of cases of this disease reported. This is true in practically every section of the country according to the current reports of the United States Public Health Service. During the corresponding month of last year there were 404 cases, and during October, 1931, there were 270 cases reported. Peculiar to this disease it has been observed that the totals fluctuate greatly from week to week.

SCARLET FEVER. Scarlet fever shows an enormous increase over the previous month and is higher than for the corresponding month a year ago when 471 cases were reported, and also higher than during October 1931, when only 293 cases were reported. Marion County with a total of 65 cases led, while other counties reporting large totals were Dubois County, 42; Lake County, 34; Laporte County, 30; St. Joseph, 45, and Vanderburgh County, 29 cases.

TYPHOID FEVER. As was expected, considering the season of the year, a great decrease was shown in typhoid fever compared with the month of September. The cases were widely spread throughout twenty-three different counties, Monroe County leading with a total of eight cases.

POLIOMYELITIS. The total of four cases of poliomyelitis for the month of October compares very favorably with ten for September and the total for October, 1932, when the total was 19. Cases were reported during October as follows: Allen County, 1; Lake County, 2, and St. Joseph County, 1.

MENINGOCOCCUS MENINGITIS. Even with an increase of one case over the previous month this disease is at a lower level than during the previous two years. Indianapolis, Marion County, reported seven cases out of the total of eight.

During October there were four cases of encephalitis lethargica reported, one case each from Cass, Clark, Huntington, and Lake counties. According to case cards submitted by the local physicians and investigations conducted by the State Epidemiologist we are of the opinion that none of the cases reported were of the infectious and epidemic type. Two of the patients were reported as having developed a form of this disease after serious attacks of influenza and pneumonia. One case of undulant fever was reported from Huntington County.

CLINTON COUNTY MEDICAL SOCIETY

The Clinton County Medical Society entertained informally the members of the dental fraternity, members of the Clinton County Bar Association, county officials and other interested citizens at an inter-professional meeting at the Hotel Coulter, November second, the gathering being in the interests of all

The main speaker of the evening was Hon. William H. Book, of Indianapolis, director of the governor's commission for unemployment relief, who explained in detail the coordinated plans that have been made.

Dr. John Morrison of Lafayette, district director of child welfare and maternal hygiene from the ninth medical district, was another speaker and at length discussed the important

part the medical fraternity was to have in conducting meetings of the physicians throughout the various districts.

I. E. CARLYLE, M. D.,
Secretary.

LAKE COUNTY MEDICAL SOCIETY

November 3, 1933.

The Lake County Medical Society met in regular session at St. Margaret's Hospital, Hammond, Friday evening, November 3. This was a dinner session, same being served by the good Sisters of the hospital, with roast turkey as the *pièce de résistance.*

Following the dinner a short business session was held.

Applications were read from Drs. W. S. Bailey, of Gary, and Susie Thompson, Gary school physician.

Ballot was had on the applications of Drs. Flavia M. Doty and Herman H. Clay, both of Gary. They were declared duly elected.

A letter was read from Dr. William D. Weis expressing his appreciation of his election to life membership.

President Jones announced the annual meeting, December 14, to be held in the Gary Hotel. Dr. Robert Lischer, Mascoutah, Illinois, is to be the guest speaker.

The guest of the evening, Dr. Walter C. Alvarez, of the Mayo Clinic, was then announced. He discussed "Functional Indigestion." His talk was a radical departure from the customary discussion of scientific subjects, in that he held aloof from all but casual references to physiological considerations of the digestive processes and laboratory methods were given seant attention during the evening. On the contrary he gave what was at once the most homely and most informative presentation of a very interesting subject that we have been privileged to hear in our society.

Dr. Alvarez was greeted by a record attendance, some 135 members being present.

Concensus of opinion following the meeting was to the effect that this was the outstanding meeting of our society.

President Jones expressed the thanks of the society to Dr. Alvarez for his excellent program.

Adjourned.

E. S. JONES, *President.*
E. M. SHANKLIN, *Secretary.*

ST. JOSEPH COUNTY MEDICAL SOCIETY

St. Joseph County Medical Society held its first fall meeting October 3, 1933, at 8:30 p. m. in the Medical Room of the Public Library, with President Graham in the chair, and with 37 members and 3 guests present.

The paper of the evening, "Irradiation of Milk," was given by Dr. H. T. Scott, University of Wisconsin. Dr. Scott spoke of the vitamins so necessary to health and especially of Vitamin D, the lack of which causes riekets in children. He told of the process of irradiating milk at the University of Wisconsin and the biologic tests carried on there with the milk so irradiated, and the results obtained. He spoke of the approval of the A. M. A. of this process and the precautions the University is taking to keep the process out of the hands of the quack advertiser. He said the process was not installed in any dairy in any county without the approval of the county medical society in that community.

The paper was discussed by Drs. Helmen, Graham, Christophel, Bolling, Bosenbury, Faltin and Miller.

As Dr. Scott wished an expression of opinion from the Society, a motion was made and carried that the matter be referred to the Committee on Public Relations, who were to report to the Society at the next meeting their approval or disapproval.

* * *

The St. Joseph County Medical Society met in the medical room of the library, Tuesday, October 10, 1933, at 8:30 p. m. with President Graham presiding over thirty-two members and six guests.

Dr. Sennett, Chairman of the Public Relations Committee, reported that as yet there was no report to be made on Irradiation of Milk.

The secretary, at the president's request, read a communication of September 14, 1933, from the Executive Secretary of the Indiana State Medical Association to the secretaries, officers, councillors, and members of the president's Special Committee on Fee Schedules on "Plan whereby Federal Emergency Relief Act Funds may be made available to reimburse physicians who have rendered medical services in emergency cases in the treatment of the indigent sick." This communication together with its enclosure, "Emergency Medical Aid to the Indigent," was ordered to be turned over to the Public Relations Committee so that an early report may be made and the proper action may be taken by the society.

The resignation of Dr. A. P. Forbes Gammack, dated October 7, 1933, from the St. Joseph County Medical Society was read.

Motion was made and carried that Dr. Gammack's resignation be accepted.

A motion by Dr. Wygant to change the date of the annual meeting from November 22, 1933, to November 15, 1933, if possible without inconvenience to the plans of the committee and the speakers, was seconded by Dr. Duggan, and carried.

The paper of the evening was given by George Peabody, Managing Editor of the *National Anti-Nostrum Magazine*, on "Nostrums and Quackery." Mr. Peabody gave interesting figures of the amount of money spent for nostrums as against that spent for scientific medicine, and the immense amount of advertising done by quacks in all sorts of reputable papers and magazines. He spoke of Crazy Water Crystals, so widely advertised today over the radio and in the papers. He asks the backing of the medical world in his fight against this type of fraud.

The paper was discussed by Drs. Haley, Graham and Wygant.

* * *

The St. Joseph County Medical Society met in the medical room of the library, Tuesday, October 17, 1933, and was called to order by President Graham at 8:45 p. m., with 32 members and one guest present.

Dr. Bickel, a member of the Public Relations Committee, reported in the absence of Dr. Sennett, its chairman, that the committee had received a reply from the A. M. A. relative to the Irradiation of Milk, which stated that the A. M. A. had not approved the plan of the University of Wisconsin in putting the irradiation of milk before the county medical societies. The Public Relations Committee, therefore, wished for more time to gather more information before a final report is given.

The paper of the evening was given by Dr. Marcus Lyon, on "Basal Metabolism: Correlation of the findings from the tables of Jenkins based on the pulse rate-pulse pressure complex (*Arch. Int. Med.* Vol. 49, pp. 188-198, Feb., 1932) with those of the metabolimeter."

The paper was discussed by Drs. Sensenich, Wilson, Giordano, Hyde and Frash.

Dr. Selby called the attention of the society to a moving picture on "Modern Hospital Care" which he thought would be well worth showing, if some arrangement could be made with a theatre as sponsored by the St. Joseph County Medical Society. Dr. Sensenich thought it might be used in connection with the approaching Community Drive. It was moved by Dr. Bickel and seconded by Dr. Sensenich that a committee be appointed to arrange for this.

Dr. Carter reported that a young woman had called him, asking him to advertise (at a cost of $5.00) in a directory that was being gotten out by a church. On replying that such advertisement was unethical for the medical profession, he was then asked to contribute $3.00 to the support of the church. Later investigation showed this to be a private enterprise of two young women from another state, and that a printer of South Bend was submitting a bid to publish the whole issue of the directory for $10.00. Each family in the church was to receive one copy. How much the church was to receive, or whether the church was actively behind this money-making scheme, was not known. It was decided that the medical society could do nothing other than warn its members of the racket and leave other action to the church and the police.

MARTHA BREWER LYON, M. D.,
Assistant Secretary and Treasurer.

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